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ABSTRACT

One of a series of studies, this monograph presents descriptive information to provide an understanding of the present budgetary system for Community Mental Health Centers (CMHCs) as it relates to Mexican Americans in Texas. The document: (1) provides a description of federal and state laws and their historical evolution germane to the funding of CMHCs: (2) explains the appropriation system that Texas follows for its biennial budget; and (3) describes the sources of funds and the methods of securing them. An explanation of the grant-in-aid process employed by Texas is given indicating that no policy currently exists in the funding criteria that specifically creates policy which addresses the mental health needs of Mexican Americans, the state's largest linguistic minority group: however, information is presented which reveals an effort to reformulate this policy as of May, 1980. The paper also examines the relationship between the amount of a center's aid and the Mexican American population in the center's catchment area, and between the aid and the ethnic content of the centers' programs. No direct relationship is indicated, and further research is recommended to identify the variables and values needed to be included in budgeting systems to ensure that all populations, including special linguistic ones, are adequately and appropriately served. (Author/JD)

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Budget Allocation for
Community Mental Health Centers in Texas:
Process and Reality
Implications for Mexican Americans

by

Bernadette A. Brusco

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BUDGET ALLOCATION FOR COMMUNITY MENTAL HEALTH CENTERS IN TEXAS: PROCESS AND REALITY IMPLICATIONS FOR MEXICAN AMERICANS

ABSTRACT

A description of the federal and state laws and their historical evolution germane to the funding of community mental health centers (CMHCs) is provided.

The appropriation process that Texas follows for its biennual budget is explained, with emphasis placed on the role of community mental health centers within this process. In addition, the sources of funds and the various methods of securing these funds are described.

An exploration of the grant-in-aid process employed by the Texas Department of Mental Health Mental Retardation indicates that no policy currently exists in the funding criteria that specifically creates policy which addresses the mental health needs of Mexican Americans, the state's largest linguistic minority group. Information is presented which documents the evolving policy surrounding the grant-in-aid, and the current effort which TDMHMR is putting forth in reformulating this policy as of May 1980.

The relationship between the amount of a center's grant-in-aid and the Spanish Language/Spanish Surname population in the center's catchment area is explored. The paper also examines the relationship between the grant-in-aid and the ethnic content of the centers' programs for fiscal year 1980, as presented in the centers' planning and budget documents. Findings indicate that there is no direct relationship. The study provides the basis for additional research into the relationship between the levels of funding of CMHCs and the Mexican American population.

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I wish to acknowledge the constructive criticism and invaluable suggestions made by my friends and colleagues at IDRA: David Ramirez, Dr. Ramiro Valdez, Sharon Sepulveda Hassell, Daniel Muraida, Alberto Cortez and Mary Binder. To friends, Dr. Sidney Plotkin and Dr. R. Michael Stevens who gave their time and energy, I am grateful.

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Special thanks to the wonderful support staff at IDRA, Laura Douglass, Dianna Coker, Linda Cervera, Ed Maldonado, Juan Luis Tercero and particularly to Rosario Trejo, without whom this monograph could not have been completed.

MENTAL HEALTH RESEARCH PROJECT OF THE INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

The Intercultural Development Research Association's Mental Health Research Project (MHRP), funded by the National Institute of Mental Health, seeks to improve mental health delivery systems for Mexican Americans in the state of Texas.

The MHRP's major goals include: 1) a preliminary analysis of the effectiveness of the state mental health service delivery system and subsystems in providing services to Mexican Americans; 2) an assessment of the community mental health center concept as it relates to the Mexican American population; 3) the design of a bilingual/multicultural human service delivery model relevant to the mental health needs of Mexican Americans in Texas; and 4) the development of policy and programmatic alternatives to enhance the utilization of the state mental health service delivery system by Mexican Americans.

The MHRP has established a Texas Advisory Committee which consists of mental health service deliverers, professionals/academicians and consumer representatives from the five major geographical regions of Texas. The committee members serve as conduits for information dissemination and collection. To ensure maximum generalizability of the process and products of the MHRP, six nationally recognized professionals in the area of mental health and service delivery systems serve as consultants to the MHRP in the form of a National Advisory Committee.

The goal of the IDRA Mental Health Research Project is improved services for Mexican Americans in the state of Texas. Because a lack of agreement has existed in Census surveys and social science research as to the definition of a "Mexican American," potential problems emerge in attempting to compare data sources across regions or time frames. Terms encountered historically to identify this ethnic group include: Mexicans, Mexican Americans, Spanish-surnamed, Spanish-speaking, Latin

Americans, Spanish Americans, Hispanics, etc. The term "Mexican Americans" is used consistently by the Mental Health Research Project to refer to this population, indicating those residents who are of Mexican origin or descent. References to specific data sources may at times utilize the exact label cited therein (e.g., "Spanish Americans"); it is assumed by the project that the overwhelming majority of any such individuals in Texas are of Mexican origin.

Mental Health Research Project Staff

David G. Ramirez	Project Director
Ramiro Valdez, Ph.D.	Research Coordinator
Bernadette A. Brusco	Research Scientist
Sharon S. Hassell, A.C.S.W.	Field Researcher
Criselda S. Price, M.A.	Research Assistant
Janice Pape	Data Analyst
Sally J. Andrade, Ph.D.	Project Evaluator
Rosario H. Trejo	Project Secretary

TABLE OF CONTENTS

Page

Introduction 1

Chapter I - Funding Community Mental Health
Centers from the Federal Level:
Legislative History 5
National Trends in Federal Funding
of Community Mental Health Centers 12
Additional Sources of Federal Funds 17
Summary: Federal Funding in the Future
for Community Mental Health Centers:
Implications for Mexican Americans 18

Chapter II - Texas Budgetary Process
A Brief History and General Overview 20
Appropriation Process 22
The Five Steps of the Appropriation
Process 24
The Legislative Budget Board 36
Zero-Base Budgeting and its Implications
for Mental Health Services to Mexican
Americans 42

Chapter III - Budgetary Process for Community
Mental Health Centers in Texas
Texas Department of Mental Health Mental
Retardation and the Grant-in-Aid 47
Grant-in-Aid Process 49
Awarding Grants-in-Aid 55
Additional Sources of State Funds 58
Funding Community Mental Health Centers
from the Local Level 64
Trends in Funding Community Mental Health
Centers in Texas 66

TABLE OF CONTENTS
(Con't)

Page

Chapter IV - Implications for Mental Health Services to Mexican Americans 72
  Population as a Variable in Community Mental Health Center Budget Allocation 75
  Stated Ethnic Program Content as a Variable in Community Mental Health Center Budget Requests 80

Conclusion 82

Appendix I: Survey of CMHC Funding Mechanisms in 47 States 85

Appendix II: Selected Zero-Based Budget Forms 102

References 115

LIST OF TABLES

Page

Table 1 Distribution of Funds by Source for a Cohort of Federally Funded Community Mental Health Centers and Average Percent Change, United States, 1971-1975 16

Table 2 Texas Department of Mental Health Mental Retardation General Appropriations: As Presented in the General Appropriation Bill 32

Table 3 Texas Department of Mental Health Mental Retardation General Appropriation: As Presented in Recapitulation Section of General Appropriations Bill 35

Table 4 House Bill 3 Provisions for State Grants-in-Aid 48

Table 5 Texas Department of Mental Health Mental Retardation Grant-in-Aid Formula for FY 1977 50

Table 6 Texas Department of Mental Health Mental Retardation Center Grant-in-Aid Formula for FY 1978-1979 52

Table 7 Texas Department of Mental Health Mental Retardation Center Grant-in-Aid Formula for FY 1980-1981 54

Table 8 Four Alternatives Under Consideration for the Awarding of State Grants-in-Aid to Community Mental Health Centers in Texas, February 1980 59

Table 9 Percent of Texas Department of Mental Health Mental Retardation Appropriation Allocated Community Mental Health Centers in Texas 70

Table 10 Comparison of Populations and Funding Levels at Community Mental Health Centers in Texas 77

Table 11 Population Clusters Based on Total Population of Community Mental Health Center Catchment Areas, from 1970 Census 79

Table 12 Comparison of the Total Number of Programs Offered by Community Mental Health Centers in Texas and Programs with a Stated Ethnic Component for FY 1980 83

LIST OF CHARTS

Page

Chart 1 Selected Funding Sources as a Percent of Total Funds (1971-1975) 13

Chart 2 Estimated Annual Funds by Source (current dollars) Federally Funded Community Mental Health Center Program 1971-1975 15

Chart 3 Texas Community Mental Health Centers Budgetary Process for Grants-in-Aid 23

Chart 4 Total Appropriations for Texas Department of Mental Health Mental Retardation Excluding Construction Funds 68

Chart 5 General Revenue Appropriations for Contract Treatment Services and State Grants-in-Aid 1966-1981 69

Chart 6 Comparison of Financial Support Budgeted by Community Mental Health Center Boards of Trustees 1971-1981 71

INTRODUCTION

This monograph is one of a series by Intercultural Development Research Association's Mental Health Research Project which explores the community mental health service delivery system as it relates to Mexican Americans in Texas. The data presented here are of two kinds. First, descriptive information is presented to provide an understanding of the present budgeting system. Such an understanding is crucial for future research into community mental health services to Mexican Americans in Texas. Second, some basic evidence is presented which explores the relationships of the levels of funding to Spanish-surnamed population and ethnic program content.

The goal of this monograph is to describe the national and the Texas legislative history in relation to the technical process of budgeting for Texas' community mental health centers, paying particular attention to the state grant-in-aid process. The emphasis is placed on the grant-in-aid process because of the importance attached to the continued availability of these state funds for the future of community mental health centers. Too often research which culminates in recommendations is never seriously considered for implementation because not enough is understood about the existing system. The recommendations and/or the suggested method(s) of implementation are often unrealistic. They are presented in a vacuum (Kramer, 1979). To avoid such an approach, a comprehensive description of the funding process is presented to enable the reader to understand the system. The data in this monograph will provide answers to the following questions: 1) What is the procedural process for budgeting? 2) When attempting to initiate change in the mental health system, what kind of problems might emerge because of the budgeting mechanism? and 3) who (which "actors") are involved in the budget allocation process?

One of the more complicated aspects of social policy formulation and implementation is the funding component. The questions of who pays what to whom, when, for how long and under what conditions can become more contested than the social policy's programmatic goals and objectives. As these questions are answered, regulations and procedures are established for funding the program. Implicit in the regulations and procedures are values that may or may not be related to program issues. Whatever the values, it becomes just as important to understand the funding history and mechanisms as to be acquainted with the content of the program. Unfortunately, the funding mechanism can take on a "life of its own." Often content changes and amendments in a program cannot be made because of constraints in the funding mechanism (Wildavsky, 1964).

Understanding the process, the history and legislation of budget allocation is vital in evaluating a program and in developing new social policy. When this technical process is understood, questions of how decisions are made can be addressed. Since budgeting is an imperfect art/science involving absolute amounts, hard and fast answers as to how decisions are made can be difficult to provide. It is inappropriate to assume that because discrete money amounts are involved that a discrete, systematic and identifiable decision-making process is employed in the budget allocation (Starling, 1979). Many subjective variables outside this technical process play important roles in the final funding decision (Riechken, 1979). This monograph will not identify or catalogue the subjective variables; rather, information will be presented to show how one type of budget allocation, the state grant-in-aid, does not appear to relate to easily identifiable objective criteria.

The information and data for this study were obtained in several ways. A review of the federal and state laws was conducted, along with accompanying documents such as congressional reports. Material from the Texas Department of Mental Health Mental Retardation was also reviewed. Site visits were conducted at seven community mental health centers and various staff and Board of Trustee members were interviewed. Interviews were also held with people from: TDMHMR, Community Services Division, Planning and Resource Development Division and the Commissioner's Office; Legislative Budget Board staff; the Texas Council of Community MHMR Centers; Citizens for Human Development; staff for the Special Committee on Delivery of Human Services in Texas (SR 67); and the Department of Health, Education and Welfare, Region Six.

This monograph also will begin to explore the issue of the relationship between the level of grant-in-aid funding for community mental health center programs and Mexican Americans. First, some exploratory information will be presented which focuses on the relationship between the Mexican American population in the community mental health centers' catchment areas and levels of funding. Second, the focus will be on the relationship between the level of funding and the ethnic content of programs that are aimed at Mexican Americans. In addition, data are presented to show national and Texas trends in funding community mental health centers.

In Texas, community centers which provide mental health services are referred to as community mental health mental retardation centers. In the body of Community Mental Health Center federal law, the reference is to community mental health centers (CMHCs). Both terms refer to the same entity in Texas. Since this monograph deals with the federal law and legislation, and with the Texas system, the term CMHC will be used when referring to either the centers in the state system, in other states or to the federal law.

By itself, this study does not provide the reader with a comprehensive picture of the relationship between the mental health needs of Mexican Americans and the policies of the CMHC system in Texas; nor will it address all the relationships between funding and the mental health needs of Mexican Americans. This monograph is just one research building block in moving closer to an eventual definition of the service delivery questions at issue and the identification of possible solutions for appropriately addressing the mental health needs of Mexican Americans in Texas. As a unified body of work, the reports and monographs of the IDRA Mental Health Research Project hopefully will accomplish such a goal.

CHAPTER I

FUNDING COMMUNITY MENTAL HEALTH CENTERS FROM THE FEDERAL LEVEL

Legislative History

Community mental health centers (CMHCs) obtain their funding from three major sources: 1) the federal government, 2) the state government, and 3) local sources (which may include local governments, and private or public entities). This multi-source funding system is very complex, with a wide array of eligibility requirements and matching formulae. A CMHC must engage in the appropriation process of each source simultaneously, since the amounts requested by the centers and those appropriated by the source in some ways are dependent upon each other. Sometimes there is a formal relationship between the funding source and the center as expressed in mandated matching requirements; in other instances the appropriating source merely reviews informally the amount and origin of funds desired from other sources. In the informal review procedure, it is difficult to diagram the relationship of the different sources of funding allocation in an appropriation decision because all the relationships are unstructured. This is not the case with the federal contribution to the CMHC program since it is based on a declining formula over a limited period of time. This federal CMHC grant is intended to serve as "seed" money to initiate and support CMHCs while they are generating monies from local and state sources; eventually the federal support will cease, and the CMHC should be sustained by state and local money.

The evolution of enabling legislation for this multi-source funding system at the state and federal levels has not been smooth. Changes in federal administrations have brought periods of proposed phase-out and block grants, vetoes of the entire CMHC appropriations, federal court suits which sought to defund the system totally, and attempted executive impoundments of funds when Congress overrode an executive veto (Brusco, 1979; Bloom, 1975).

Over the past decade, each state has evolved a body of laws and regulations for funding CMHCs. These regulations affect the degree of appropriation and oftentimes reflect each state's ability to meet a funding commitment for CMHCs (see Survey of CMHC Funding Mechanism in 47 States, Appendix I). While each state's legislative response varies, the future of funding for CMHCs remains the number one concern among CMHC administrators nationally and in Texas (Mental Health Research Project, 1979; Board Training Project of 1976, 1977; National Institute of Mental Health, 1977).

Federal support for CMHCs falls into two categories: construction funds and operational funds (staffing and specific programmatic support). The first piece of federal enabling legislation to aid in establishing CMHC services was the Mental Retardation Facilities and Community Mental Health Center's Construction Act of 1963 (Public Law 88-64). The Act authorized a total of $150 million in construction funds for 1965-1967. Limited federal funds were available on the basis of three considerations: 1) population, 2) the extent of facility need, and 3) the overall financial need of the states. There was considerable controversy over the funding provisions of the Act, and passage remained doubtful until the section providing for federal support of staffing was deleted (Brusco, 1979; U.S. Senate, 1973).

In 1965, Congress passed the Community Mental Health Center's Construction Act Amendments of 1965 (Public Law 89-105), which expanded the federal investment in CMHCs by providing federal funds for the initial staffing of the centers. President

Johnson urged passage, pointing out that "facilities" alone cannot assure service costs for professional and technical personnel (National Institute of Mental Health, 1977). These monies were available to centers constructed under Public Law 88-64 and to existing centers which were willing to add new or additional mental health services. Grants were authorized on a decreasing matching percentage for a maximum period of 51 months. The Act authorized a total of $73.5 million for 1966-1968.

Congress did not move easily into the area of funding staffing. There was a great deal of debate on this question. The accompanying Congressional Report to PL 88-64 stressed that the intent of the legislation was not to transfer to the federal government the traditional responsibility of the states to provide mental health care, but rather to provide financial assistance in the CMHC's transitional period (U.S. Senate, 1965).

With the passage of the Mental Health Amendments of 1967 (Public Law 90-31), Congress extended the authorization for construction and initial staffing grants for 1968-1970. Construction was redefined to permit the acquisition of existing buildings for CMHC use. A total of $180 million was authorized for construction, and an additional $58 million for staffing. During the same congressional session in which Public Law 90-31 was passed, Congress also passed the Partnership for Health Amendments of 1967 (Public Law 90-174) which expanded health services. The act established allotments to each state's mental health authority to assist in meeting the costs of providing comprehensive mental health services. In so doing, this act became the first to present statutory language targeting a specific ratio of assistance that must be used for service delivery (70%) and administrative support (30%). The allotments were established thus:

> In any fiscal year not less than 15 per centum of a state's allotment shall be made available only for grants for the provision of mental health services and not less than 70 per centum of the amount of a state's allotment which is made available for grants to the mental health authority, shall be available only for the provision of services in communities of the State. (Public Law 90-31)

The original scope and purpose of the CMHC Act was broadened with the passage of the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 (Public Law 90-154). New programs for construction were added, as were new areas for staffing assistance for the treatment of alcoholism and narcotic addiction. Facilities now were entitled to grant assistance in amounts not to exceed two-thirds of the costs of facility construction. States now were authorized to use two percent of their allotment funds, not to exceed $50,000, to meet the costs of program administration. All states also were subject to a maintenance of fiscal effort provision which provided a minimum level of funding. A total of $40 million was authorized for 1969-1970.

From 1963 to 1970, each successive piece of federal CMHC legislation further extended the grant period and broadened both the scope of the original Act and the funding by creating new funding formulae. In 1970, Congress evaluated the direction of the federal investment for the CMHC program, along with the original intent to view federal money as seed money for the CMHC program. The conclusions of the Congress were that state and local sources of funding had been inadequate and that the development of funding resources through general health insurance, medical assistance programs, private insurance plans and other third-party payments had not progressed well. Congress concluded that, overall, the initial expectation regarding non-federal funding of CMHCs may have been too optimistic. These conclusions were reported in a U.S. House Report (U.S. House, 1969).

Congress then passed the Community Mental Health Center's Amendments of 1970 (Public Law 91-211) which reflected their conclusions and findings as reported in the House Report of 1969. The federal share of the costs of center construction was increased, with CMHCs in urban or rural poverty areas receiving up to 90% in federal funds for construction. Centers not in targeted areas could also receive greater support. The declining federal matching formula used to determine staffing grants was also changed so that centers in non-poverty areas could receive staffing money for up to eight years rather than 51 months. The percentage of state allotment authorized for administrative costs was raised from two to five percent. Additional initiation grants were provided expressly for assessing local mental health needs, designing center programs and developing services. The 1970 Amendments authorized $270 million for center construction and $155 million for operational grants for 1971-1973.

In 1973, President Nixon sought to terminate the community mental health centers program by interpreting the federal participation in the program as being limited to demonstration projects. This view was overturned by Judge G. Gessell, U.S. District Court for the District of Columbia in August 1973. (National Council of Community Mental Health Centers vs. Weinberg). This action prompted Congress to review completely the CMHC program history. As a result of this review, the Health Revenue Sharing and Health Services Act of 1975 (Public Law 94-63) was passed.

Public Law 94-63 provided a complete definition of a comprehensive community mental health center. Centers were now required to provide specific services. These have become known as "the 12 minimum essential services." They are presented in the Act as:

1. partial hospitalization;
2. emergency service;
3. consultation and education;
4. inpatient care;
5. outpatient care;
6. specialized services for children;
7. specialized services for elderly;
8. drug abuse and alcoholism services;
9. halfway houses and follow-up care;
10. screening services for prospective patients of public psychiatric inpatient facilities;
11. consultation and education services in specific areas; and
12. assistance to the courts.

Six new "granting program areas" were created:

Planning
Operational Support
Conversion
Consultation and Education
Financial Distress
Facility Assistance

An eligible center could apply for federal funds in any or all of these program areas. One of the most significant new funding policy provisions was the creation of the granting program area for financial distress grants. These would be made available to centers at the end of their eight-year operating or staffing grants if the center could demonstrate that loss of federal money would impair the quality of service and reduce service. Subsequent acts have continued to expand the federal investment in CMHCs while maintaining the program as defined in Public Law 94-63. However, as of May 1980, Public Law 94-63 remained the major federal legislation for CMHCs.

At the federal level, financing of the CMHCs has continued to be a major concern. In 1978, the Senate undertook an examination of the financing of CMHCs and reported that CMHCs had yet to develop stable, adequate, non-federal funding sources. The Senate posed the question of the viability of extending the eight-year funding policy but offered no recommendation (U.S. Senate, 1978). This report influenced the passage of the Community Mental Health Center Extension Act of 1978-Title I (Public Law 95-622), which authorized a significant increase in the appropriations for financial distress grants. It also increased from three to five the number of financial distress grants that can be made to any one center. Unexpended funds from operations and staffing grants may be carried over from one fiscal year to the next. CMHCs were required by law to offer "the 12 minimum essential services" in order to obtain federal funds and begin operation. In reality, however, few centers were able to do so. Under this new law, CMHCs in operation for less than three years may gradually phase-in the 12 mandated essential services. Finally, two new program grant areas, planning and monitoring, were created. Money was made available to state mental health authorities for carrying out the health planning functions and monitoring of CMHCs to determine if requirements of the law were being met by federally funded CMHCs.

National Trends in Federal Funding of Community Mental Health Centers

In the period from fiscal year (FY) 1966 through FY 1976, federal funds assisted in the creation of 650 CMHCs, for an average of 56 a year. Of these 650 centers, 478 received construction funds and 531 received operation funds. The average federal construction grant obligation for this period was $24 million per year, with staffing obligations averaging $96 million per year (National Institute of Mental Health, 1977).

While a review of the legislative history demonstrates increasingly larger dollar amounts being appropriated to CHMCs over the last 16 years, the overall federal contribution has actually decreased. This occurred because the increasing rate of appropriations did not keep pace with the increasing number of CMHCs. Actually, all the centers receive fewer federal dollars each year. In addition, the level of the federal general appropriation has not kept pace with inflation.

Each year the CMHCs provide information to the federal government which is reported as the Inventory of Comprehensive Community Mental Health Centers. These data, presented as cohort, estimated and actual data, document the federal funding trends. The data presented in Chart 1 are from a selected cohort of federally funded CMHCs for the period of 1971-1975. They indicate that federal funds (not from direct services) have decreased over time. Chart 1 illustrates an increasing proportion of revenues from direct services (from 23% to 32% of total revenues for 1971 to 1975) and the relatively stable contributions made by state/local government sources and other non-governmental sources.

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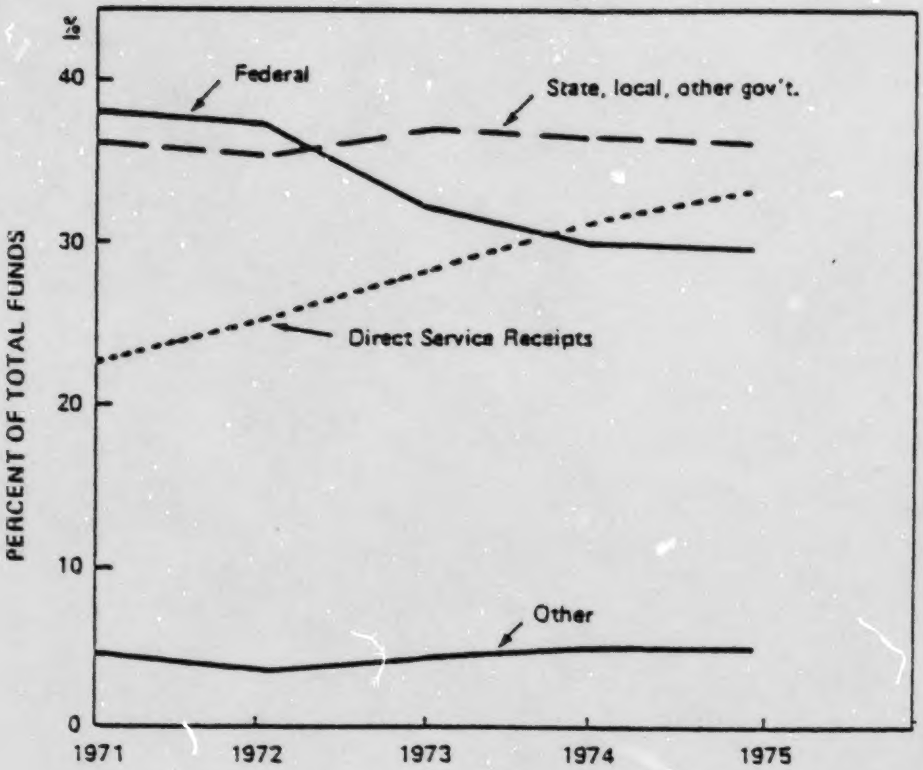
CHART 1

SELECTED FUNDING SOURCES AS A PERCENT OF TOTAL FUNDS
(Based on a selected cohort of federally funded CMHCs)
1971-1975



Source of Funds	Percent Distribution				
	1971	1972	1973	1974	1975
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Federal	37.5	36.9	31.6	29.3	29.1
State, Local, other gov't.	35.8	34.9	36.5	34.8	34.3
Direct Service Receipts	22.5	24.9	27.9	31.5	32.3
Other	4.2	3.3	4.0	4.4	4.3

(National Institute of Mental Health, 1977.)

In the years 1971-1975, the number of dollars from each center's major sources of revenue increased. This increase, shown in Chart 1, includes the addition of new centers. Chart 2 shows that, in 1971, CMHC revenue from all sources totaled $302 million for 295 centers, and by 1975, had increased to $799 million for 528 centers. This increase is adjusted for the inflation rate and presented in current and constant dollars. Constant dollars are determined on the medical care component of the consumer price index:

YEAR		INDEX
1971	-	100.0
1972	-	103.2
1973	-	107.2
1974	-	117.2
1975	-	131.3

(National Institute of Mental Health, 1977)

Over time, the distribution of a center's revenue shows a declining federal contribution, an increase in contributions from direct services, and a stable contribution from state and local sources. These trends are more clearly seen in Table 1. These data, for a cohort of 125 centers by source of funds, show that only federal staffing dollars decreased. Federal funds from all other sources increased from five percent in 1971 to nine percent in 1975.

When this table is examined for trend data on the state and local share of revenue, it is clear that the state share has doubled. Between 1971 and 1975, state funds increased from $234 thousand to $464 thousand per center for the cohort centers.

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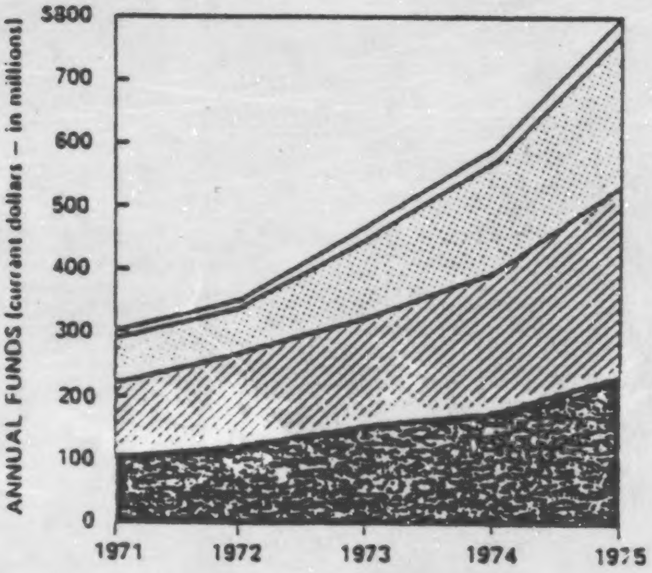
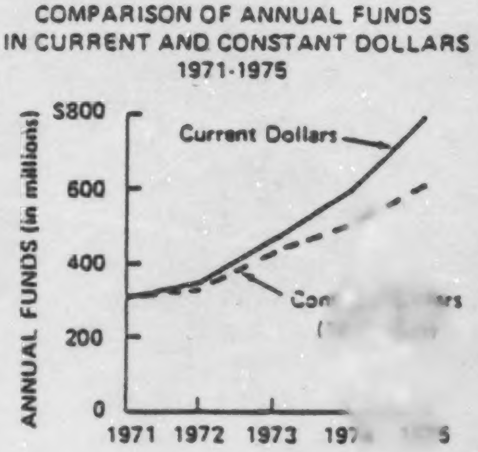
CHART 2

ESTIMATED ANNUAL FUNDS BY SOURCE (current dollars)
FEDERALLY FUNDED CMHC PROGRAM
1971-1975





Source of Funds	1971	1972	1973	1974	1975
	Number of Dollars (in millions)				
	Current Dollars				
Total	$302	$345	$465	$590	$799
■ Federal	103	122	157	178	238
▨ State, Local, other gov't.	116	140	165	216	302
░ Direct Service Receipts	72	73	125	174	232
☐ Other	11	10	18	22	27
	Constant Dollars (1971 Base)				
Total	$302	$335	$434	$504	$608
Federal	103	118	146	152	181
State, Local, other gov't.	116	137	154	186	229
Direct Service Receipts	72	71	117	148	177
Other	11	9	17	18	21
Number of Centers	295	325	400	434	528

(National Institute of Mental Health, 1977.)

TABLE 1

DISTRIBUTION OF FUNDS BY SOURCE FOR A COHORT OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS AND AVERAGE PERCENT CHANGE, UNITED STATES 1971-1975

Source of Funds	1971	1972	1973	1974	1975	Ave. % Change 1971-1975
			a. Average per center			
Federal Staffing	304,526	375,368	380,937	397,459	402,734	7.2%
Other Federal	50,649	37,720	39,738	63,374	141,415	29.3
State	234,489	271,291	348,118	397,297	463,767	18.6
Local	95,206	109,479	131,451	140,513	176,373	16.7
Other Government	10,399	10,181	5,232	7,083	1,919	-34.5
Patient Fees	55,520	51,771	55,968	71,802	73,836	7.4
Insurance	75,479	100,331	105,098	120,997	154,424	19.6
Medicare	14,103	15,746	20,663	35,032	40,259	30.0
Medicaid	49,198	88,089	128,358	159,208	200,386	42.1
Other Receipts	19,294	24,700	59,515	107,853	135,483	62.8
Other	40,272	37,440	53,359	68,979	81,117	19.1
Total	949,135	1,122,356	1,328,637	1,569,597	1,871,713	18.5
			b. Percent distribution			
Federal Staffing	32.1	33.4	28.7	25.3	21.5	
Other Federal	5.3	3.4	3.0	4.0	7.6	
State	24.7	24.2	26.2	25.3	24.8	
Local	10.0	9.8	9.9	9.0	9.4	
Other Government	1.1	0.9	0.4	0.5	0.1	
Patient Fees	5.8	4.6	4.2	4.6	3.9	
Insurance	8.0	8.9	7.9	7.7	8.3	
Medicare	1.5	1.4	1.6	2.2	2.2	
Medicaid	5.2	7.8	9.7	10.1	10.7	
Other Receipts	2.0	2.2	4.5	6.9	7.2	
Other	4.2	3.3	4.0	4.4	4.3	
Total	100.0%	100.0%	100.0%	100.0%	100.0%	

(National Institute of Mental Health, 1977.)

The two largest reimbursement sources for direct services were commercial insurance and Medicaid. Both of these sources have increased in their share of dollars since 1971. The steep rise in Medicaid reimbursements was largely responsible for the increase. Medicaid reimbursements more than doubled, from five percent in 1971 to 11 percent in 1975. One cannot, however, overlook the second category of greatest increase: monies classified as "other receipts" for direct services. These monies are reimbursements from contracts for direct services, which are paid on a fee-for-service basis. This source tripled in the period of 1971 to 1975. This was due in part as the result of a reclassification of these reimbursements. Reimbursements under federal program Titles IV and XVI are no longer classifed as state funds. Now they are classified in a separate category. They were reclassified because reimbursements under Titles IV, XVI and XX are earned on a fee-for-service basis, and it was felt that such a new classification system more accurately represented the type of payment made and the source of monies.

Additional Sources of Federal Funds

There are other sources of federal funds available to CMHCs that are not tied to any of the CMHC legislation -- programs which are independent of the CMHC legislation. Monies under these programs can be awarded to all types of institutions, the CMHCs being just one of many. Funding formulae, eligibility requirements and programmatic requirements vary from one program to another. Community mental health centers are on their own in going after these funds.

As Congress introduces new programs and discontinues others, federal funding sources available to CMHCs are constantly changing. Some of these sources include:

Department of Agriculture, Washington, D.C.
Health Education and Welfare, Early Childhood Assistance Programs, Washington, D.C.
Health, Education and Welfare, Bureau of Prisons, Washington, D.C.
Health, Education and Welfare, Manpower Services, Washington, D.C.
National Institute for Drug Abuse, Washington, D.C.

Summary: Federal Funding in the Future for Community Mental Health Centers: Implications for Mexican Americans

Through the 12-year history of the CMHC movement, even while the federal appropriations have increased, the eligibility requirements broadened and the grant life of program money extended, the basic funding philosophy has not changed. Federal funds are still intended as "seed" money to sustain CMHCs while the centers develop other sources of funds. Can the CMHC program nationwide survive the phasing-out of federal operational and construction grants? From the figures presented in the preceding charts and tables, it would seem unlikely.

The question of extending the eight-year federal staffing grant by changing the federal policy is crucial to the continued survival of CMHCs. Distress funding, though making additional operational money available, does not change the original policy. Although specially raised by the Senate in the 1978 Senate Report (U.S. Senate, 1978), this issue was still unresolved, as of May 1980.

The question of federal funding for CMHCs in the future holds a special meaning for Mexican Americans in Texas and probably in other states. As the federal dollar contribution to

CMHCs declines without an equal or greater increase in funds from other sources, services may be curtailed. This cutback of service would impact negatively on the populations currently receiving services and on those who are underserved or not appropriately served. Mexican Americans fall into both these populations and, therefore, would be affected.

In addition, Mexican Americans in Texas may be affected in a more direct way. Texas' CMHC enabling legislation, House Bill 3, has no provision to guarantee the provision of services to linguistic minorities (Brusco, 1979). It is the federal law which targets special populations, one of which is linguistic minorities, and which mandates that CMHCs receiving federal funds provide appropriate services to those populations. This mandate gives the federal government the power to ensure that CMHCs provide programs for linguistic minorities. At this time it appears that the federal government is not enforcing this mandate in Texas. However, the provision does exist should the federal government choose to enforce it. As fewer CMHCs receive federal funds, these federal programmatic requirements for services for linguistic minorities apply to fewer and fewer CMHCs. As the federal funding stops, the federal mandate is no longer available as a mechanism to ensure provision of mental health services to Mexican Americans.

CHAPTER II

TEXAS BUDGETARY PROCESS

A Brief History and General Overview

In Texas, the bulk of state funds received by the CMHCs comes through a specific appropriation by the State Legislature to the Texas Department of Mental Health and Mental Retardation (TDMHMR). This appropriation is the state grant-in-aid. The grant-in-aid appropriation is awarded to TDMHMR which, in turn, makes a grant-in-aid award to each CMHC.

The state grant-in-aid is the keystone of the CMHC budget and the most important of the three funding sources, since it is related to all other sources of funds. The State Legislature requires that the state grant-in-aid be locally matched. In turn, the combination of state and local funds constitute the matching funds required for federal grants.

The state grant-in-aid is also central to the CMHCs' multi-source funding base because it is through the state's appropriation process that all the sources come together. This is due to the format that CMHCs are required to follow in submitting their budget requests. When a CMHC submits its budget request to TDMHMR, it must simultaneously provide a statement showing the dollar amounts received or expected to be received from the other funding sources.

Local funds come from a wide variety of sources and in widely different amounts. Securing funds from local sources involves different procedures from CMHC to CMHC. As indicated in federal legislation, the local sources of funding are to be developed by CMHCs while they are being funded by federal money.

Local funds are to be developed to such an extent that, in combination with state funds, they could sustain a CMHC. This generally has not occurred.

Texas has an appropriations and budgeting process that sets it apart from most states. In all but seven states, it is the function of the governor to prepare the budget, submit it to the legislature and implement the budget. In Texas however, it is constitutionally mandated that two budgets be prepared; one by the Governor and the other by the Legislative Budget Board (Benton, 1972).

The Texas Constitution of 1876 placed restrictions on each of the three branches of government: executive, legislative and judicial. The restrictions on the executive branch have created and maintained one of the weakest chief executive offices in the United States. While heavy restrictions were placed also on the legislative branch, constitutional amendments originating from the Legislature and adopted by the citizens over the years have given the Legislature more and more power. The Texas Legislature is the most powerful branch of government in the state and one of the most powerful legislatures in the nation. The Legislature is both a law-making body and a regulator of administrative machinery, exercising tremendous control over the constitution, public funds, establishment and abolishment of services, and the creation of new offices and state agencies. While the Texas Legislature ranks high in power compared to other states, it is one of the few legislatures which meets every other year and sits for a limited number of days (Gantt, 1969; McCleskey, 1975).

As the authority of the Legislature has grown, the trend has been for it to establish subsidiary organs to perform functions which the Legislature does not have time to perform. In 1921, the Board of Control was established as the budgetary agency for the state of Texas. The board, composed of three members appointed by the Governor with the approval of the Senate for a six-year term, compiled budgetary estimates. In 1931, the Uniform Budget Law made the Governor the state's chief budget officer and assigned mandated budgetary responsibility to the Governor. However, the role and responsibility of the Board of Control was not changed. Depending on the interest of the Governor, the gubernatorial role in budgeting varied from year to year since the Board of Control continued as the budgetary agency for the state (Benton, 1972).

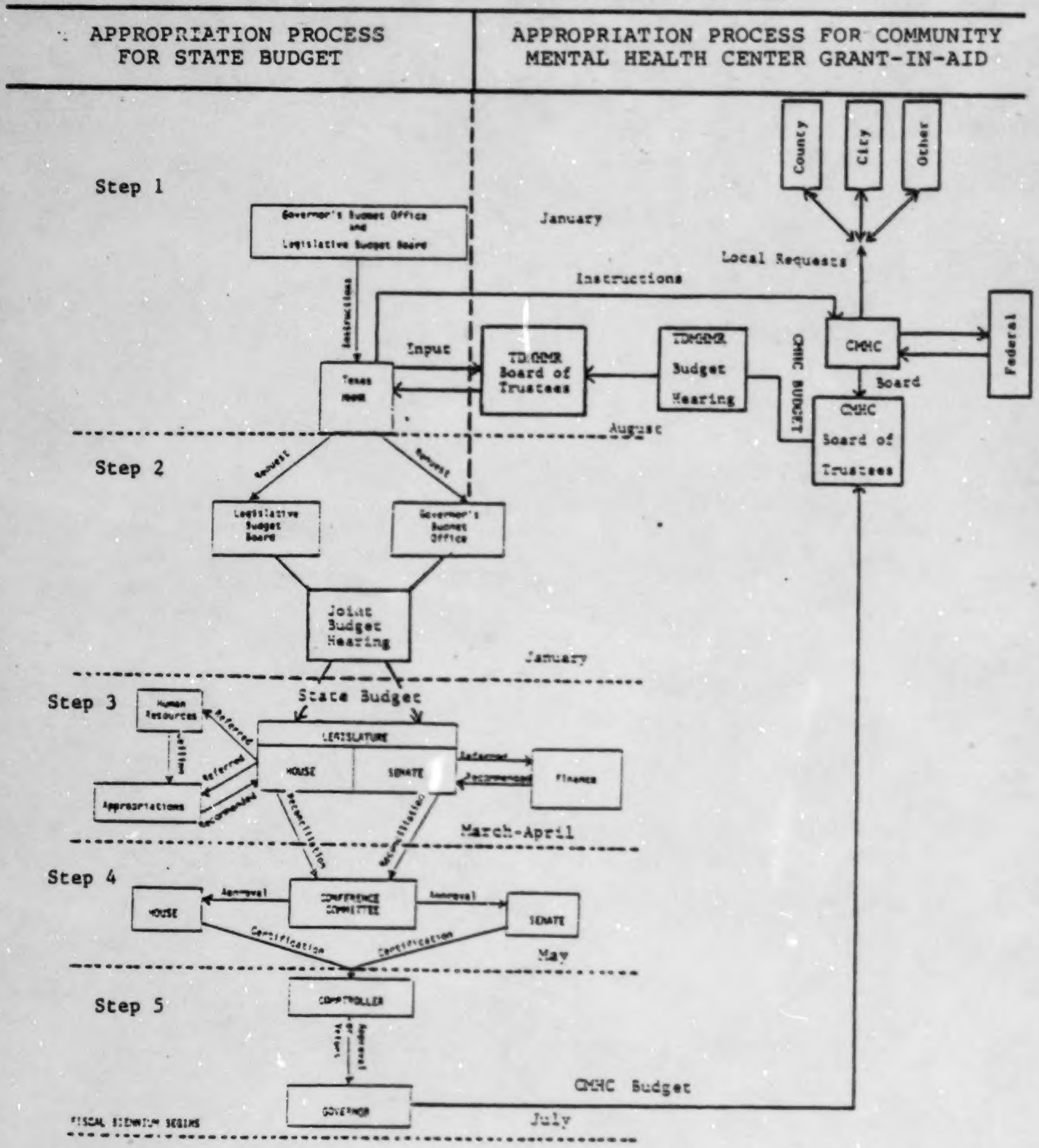
In 1949, the Legislative Budget Board (LBB) was created, composed of the Speaker of the House and four members each from the House and Senate. The LBB was responsible for preparing the biennial budget. Two years later, in 1951, the Board of Control's budgetary functions were transferred to the Governor. The Governor was required to present a budget to the Legislature five days before the beginning of a legislative session. With the implementation of the requirement for a gubernatorial budget, two budgetary systems of unequal authority were established (Benton, 1972; Pettus & Bland, 1976). As of May 1980, this dual system was still in effect.

Appropriation Process

The process of appropriating funds under the Texas General Appropriations Act is very orderly and can be broken down into discrete steps. Chart 3 graphically represents this process. It focuses on the Texas Department of Mental Health Mental Retardation (TDMHMR), but since this process is uniform throughout the state for all state agencies, commissions, institutions and departments, any one of them could be substituted in the place of TDMHMR on the chart and the state process would remain the same. The process graphically depicted to the right of the vertical dotted line is specific to the CMHCs and TDMHMR.

CHART 3

CMHC BUDGETARY PROCESS FOR GRANT-IN-AID



Note. Adopted from Farley, 1977.

As the number of programs and amount of money involved increases, the trend in all the states has been toward a more complex system of budgeting. Texas is no exception, as the state's appropriation process has grown in scope each year. The budgetary process is a series of well defined, orderly steps and directions. The process itself can be understood fairly well by anyone who has a set of the procedures, the timelines and the amounts to be requested.

Implicit in the process are assumptions and values that become as important in the area of budgetary decision-making as the dollar amounts on the budgetary request forms. In Texas, two crucial components in the appropriation decision-making process are the LBB and the Zero-Based Budget (ZBB) system. (Note: See pp. 42-46.) As in many states, Texas' budgetary process is evaluation oriented. This means that the evaluation of programs and activities are an integral part of the allocation process. Therefore, an understanding of the implicit values of the process and the functions of the process components is necessary in order to comprehend how appropriation decisions are made.

The Five Steps of the Appropriation Process

The fiscal year in Texas is from September 1 to August 31. Each budgetary period is composed of two fiscal years. Fiscal years take their name from the calendar year in which they end. In May/June of odd numbered years (these are the years in which the Legislature is in regular session), both budgetary agencies, the LBB and the Governor's Office, separately begin preparation of their proposed biennial budgets. This process is dominated by the LBB, which, over the past decade as required by the law, has designed the forms, set the timelines and produced the instructions for agencies submitting budgetary requests. All state operating agencies follow the same procedure. In order to avoid duplication, the Governor's Office has adopted the forms and instructions laid out by the LBB. In addition, the LBB and the Governor's Office cooperate in holding joint hearings. As the budgetary process is presented, the role of the LBB and Governor's Office at the various steps will be indicated.

The five general steps of the appropriation process are:

1. Preparation of requests;
2. Formulation of the statewide budget;
3. Legislative Action: passage of separate budget bills by both houses;
4. Legislative Conference Committee reconciliation of the two bills; and
5. Submission of the General Appropriation Bill to the comptroller.

1. Preparation of Requests. The first step in the budgetary process is the preparation of budgetary requests, which takes place over a period of eight months, from January through August of the year before the first year of the biennium. For the 1980-1981 biennium, the process began in January 1979.

As required by law, the LBB prepares and issues a detailed manual of instruction to each state operating agency (Legislative Budget Board, 1978). In order to simplify the process, the Governor's Office joins with the LBB in issuing the manual so that state agencies need follow only one procedure, format and timeline in submitting their budgetary requests. Each agency submits an identical copy of their budget request to the LBB and to the Governor's Office.

The technical manual spells out in detail the format and type of information required of each agency, along with the general budgetary philosophy of the state. Since 1973, a form of Zero-Based Budgeting (ZBB) has been used by the state. The ZBB system requires that for every funding period the total appropriation be justified, not just the amount that exceeds the previous years' funding. In order to do this, four levels of funding are requested for each program activity. The program activities are prioritized, then within each program, the four funding levels are ranked and submitted with program evaluation data composed of workload and performance (output) measures. To aid agencies in submitting their budget requests, the manual presents a Suggested Sequence of Events.

When the agencies receive the manual, they begin the budget preparation process for each of their programs. It is the responsibility of each agency to collect the necessary data from each of its programs in order to submit an agency appropriation request.

The budget requests from all the CMHCs are combined into one request and appear as a grant-in-aid in the Texas Department of Mental Health and Mental Retardation's (TDMHMR) budget request. In order for TDMHMR to arrive at the grant-in-aid figure to be requested, each CMHC must submit information and budget requests to TDMHMR. It is because of this that TDMHMR prepares and distributes guidelines specifically pertaining to the appropriation process for CMHCs (Community Services Division, 1978). This manual is a further elaboration of the one issued by the LBB. It includes special instructions for information that will be needed by TDMHMR in preparing the department's budget. Once the CMHCs receive the guidelines, they must begin the preparation of their budget request. Each center's request must be submitted to TDMHMR with sufficient time for the preparation of the department's budget, of which the grant-in-aid request for CMHCs is only one part.

Each center establishes its own process for setting its budget requests. The degree of input from center staff, Board of Trustees, Advisory Committees and the community at large varies from center to center. The program priorities of the State Legislature, the LBB and TDMHMR have all been forwarded to the centers in the guidelines. It is in step 1, Preparation of Requests, that these priorities are to be combined with local community needs to make up each center's locally responsive budget/program request. This is the first of four times that the local community, in theory, has access to the program establishment and priority setting in the appropriation process.

Starting with the biennium appropriations for FY 1978-FY 1979, staff of the individual centers, usually the top administrators, are called to the central office of TDMHMR for budget hearings. After these budget hearings, all of the centers' budget requests are combined into one document (TDMHMR, 1978). The budget request is submitted to the Board of Trustees of TDMHMR for approval and then submitted to the Legislative Budget Office and the Governor's Budget and Planning Office, a division within the Governor's Office.

2. Formulation of the Statewide Budget. Upon receiving the state agencies' budget requests, both state budgetary agencies (LBB and Governor's Budget and Planning Office) then begin to prepare their separate budgets. Joint hearings are held during which time TDMHMR agency administrators are called to explain the budget request submitted by their agency. Even though the final appropriation for CMHCs is not made by center but is combined for all centers into six general categories, the LBB staff can and does examine individual center's budget requests. LBB staff conduct site visits to centers and may call center staff to appear at public hearings. During these site visits, interested citizens and/or community groups, in addition to the CMHC's

boards and advisory committees, may have some contact with the LBB staff. This, however, is not usually the case. There is no required format for these site visits; thus, they may vary from one site visit to the next, and from center to center. Sometimes the LBB will request a meeting with all or some members of the CMHCs' board and advisory committees. These visits are not announced in a public notice, and citizens by and large are unaware of the presence of the LBB at the CMHC. The LBB staff examines the requested budgets on an item-by-item basis. The trend in recent years has been for the LBB staff to make major reductions in the amounts requested.

Legislative Budget Board staff recommendations are presented to the LBB, which usually makes the final decisions on the budget by the middle of December in even-numbered years. The LBB then submits its recommended budget to the Legislature for its consideration (Benton, 1972; McCleskey, 1975; Pettus & Bland, 1976).

3. Legislative Action. When the Legislature convenes in January of odd-numbered years, it has two budgets to consider - the LBB's and the Governor's. A bill is introduced in both the House and the Senate on the LBB's recommended budget so that deliberative decision-making can begin. The committee activity in each house, though slightly different, is equally important in the passage of the bill.

There are significant differences in the procedures followed in each house. In the Senate, the bill goes directly to the Finance Committee. It is this committee alone that considers the LBB's recommended budget. In the House, the procedure is more complicated. The bill is considered by two House Committees. Due to a requirement enacted in 1978, the bill is first considered by the appropriate substantive committee, which in the case of mental health mental retardation is the Health and Welfare Committee. The function of each substantive committee is to recommend to the Appropriations Committee an appropriation amount. It is up to the Appropriations Committee to fit all the substantive committees' recommendations into one budget recommendation.

Both the Senate and House hold separate hearings, but the form for each is the same. Agency administrators testify regarding the amounts requested. Interested individuals, agencies, organizations and the Governor all attempt to influence the appropriation and substantive committee members, formally during hearings and informally through lobbying, to approve their requested budget amounts. Theoretically, because of the lump sum appropriation process made to TDMHMR for the CMHCs, individuals from CMHCs and particular programs for specific CMHCs should not have any impact on the appropriation process at this stage. However, citizen input directly to legislators at this stage of the process, either formally or informally, is possible and frequently done (McCleskey, 1975). The CMHCs are no exceptions. They send their administrators and board members to testify formally at a hearing or to talk with various legislators. During this process, the LBB staff assists the Legislature in conducting the hearings and is sometimes called to testify on a wide range of issues that arise, such as: the recommended budget the LBB has presented; the LBB evaluation reports; hearings held in support of or against an appropriation; or, to comment on any question a legislator has concerning the budget. Sometimes these questions have been raised informally with the legislator by an interested citizen or group. This is another way, through the legislator, that the citizen's concern can be publicly aired and addressed in the appropriation process.

4. Conference Committee: As the two houses are conducting their hearings, there is considerable informal contact between the two. This is an attempt to "vote out" of each house the same Appropriation Bill. When this does not happen, a conference committee is formed, composed of members from each house. It is the responsibility of this committee to arrive at one Appropriation Bill acceptable to both houses.

In the past, the conference committee could determine appropriations. In recent years, however, the conference committee has been restricted to adjusting differences between the two bills. When a simple adjustment is not possible, the committee may offer to each house a concurrent resolution (Gantt, 1964; Farley, 1977).

When agreement is reached, the LBB staff drafts a final Appropriation Bill that is submitted to both houses. Separately, each house considers the bill, which must be accepted whole or rejected whole. If the bill is rejected, a new conference committee is formed and the reconciliation process (step 4) begins again. When legislative action is completed and both houses approve the same Appropriation Bill, the bill is submitted to the comptroller.

5. Submission of the General Appropriation Bill to the Comptroller: The fifth and final step in the appropriation process is a constitutional requirement. The comptroller must certify that the amounts appropriated are within the estimates of available revenue. This is to prevent deficit funding. The Appropriation Bill has never failed to be certified, as the comptroller is consulted about amounts of revenue available during the entire appropriation process.

Upon certification, the Appropriation Bill is submitted to the Governor for approval. It is at this point that the Governor can exercise a veto over the entire bill or on specific items. The Governor may not increase or decrease any amount. Numerous items are often vetoed by the Governor, but generally the whole bill is not. Vetoed items may be brought up again next session during the appropriation process.

6. Summary of the Five Steps of the Appropriation Process

It is important to remember that appropriations in the General Appropriation Bill may be detailed or quite general. For example, the appropriation for the central administrative office of TDMHMR contains highly specific line items. These items include the individual salaries and travel allowances for central office administrators. The appropriation for all the CMHCs, on the other hand, is very general. The Legislature does not appropriate money to individual community mental health centers. All centers' budgets are combined into six program categories, and the state money is awarded as a lump sum in these six areas:

1. Center administration
2. Screening and referral services
3. Outpatient services
4. Special education classes
5. Alternative residential and 24-hour residential care
6. Sheltered work training and day/evening care

Table 2 is a copy of the Central Office and CMHC appropriations as they appeared in the General Appropriation Bill for fiscal years 1980-1981.

The appropriation for each state agency, including TDMHMR, appears twice in the General Appropriation Bill. Agencies of the state are grouped together by general function, and these groups

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TABLE 2
TDMHMR GENERAL APPROPRIATIONS, AS PRESENTED IN THE GENERAL APPROPRIATION BILL

TDMHMR APPROPRIATION			EXPLANATION OF FORMAT[a]
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION			
	For the Years Ending August 31, 1980	For the Years Ending August 31, 1981	
1. Central Administration Program:			General Program Category, in this case Administration
a. Commissioner of Mental Health and Mental Retardation (plus house, utilities and $9,000 supplement from other sources)	$ 47,500	$ 49,900	Administration Line Items and Amounts for Each Fiscal Year
b. Board Member's Per Diem, 9 @ $25	5,000	5,000	
c. General Administration	515,600	523,801	
d. Budgets and Finance	605,219	635,234	
e. Legal and Claims	1,178,600	1,236,288	
f. Personnel	217,349	228,444	
g. Training	236,962	246,392	
h. Internal Audit	280,779	292,722	
i. Aircraft Operations (non-transferable)	140,025	112,777	
j. Utilities (non-transferable)	241,403	248,400 & U.B.	
k. Information Systems	2,199,435	2,264,410	
l. Plant Maintenance	332,883	348,820	
m. Design and Construction	490,718	513,329	
n. Purchasing and Supply	152,376	160,166	
o. Nutrition and Food Service	244,729	253,679	
p. Volunteer Services	97,437	102,100	
q. Planning and Resource Development	177,010	183,779	
r. Arts, Graphics and Educational Services	141,079	147,398	
s. Standards Compliance and Quality Assurance	402,140	420,248	
Subtotal, Central Administration Program	$ 7,708,542	$ 7,972,887	Category Subtotal
2. Program Administration Services:			Subcategory
a. Mental Health Services	$ 399,202	$ 374,324	Program Line Items
b. Mental Retardation Services	231,994	242,904	
c. Community Services	950,043	1,016,344	
Subtotal, Program Administration Services	$ 1,581,239	$ 1,633,572	Category Subtotal
3. Developmental Disabilities Services	$ 1,382,306	$ 1,389,943	Subcategory
4. Alcoholism Services	135,935	150,508	
GRAND TOTAL, DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, CENTRAL OFFICE	$ 10,808,022	$ 11,146,910	General Category Total
Method of Financing:			Identification of Source of Funds by Amount
General Revenue	$ 7,901,739	$ 8,219,532	
Federal Funds, estimated	1,697,508	1,705,840	
Private Grants and Departmental Revenue, estimated	9,720	9,720	
Interagency Contracts, estimated	1,199,055	1,211,818	
Total, Method of Financing	$ 10,808,022	$ 11,146,910	Total for General Program - Category
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION (Continued)			Narrative

It is the intent of the Legislature that the Department of Mental Health and Mental Retardation shall be the state agency in Texas to receive and administer federal funds allocated to the state for programs in the field of mental health and mental retardation.

To finance a system of institutional services for the mentally ill and retarded and to secure an equitable distribution of state funds for such purposes, the Department of Mental Health and Mental Retardation shall from funds appropriated in this Act, devise and establish formulas for the use of said Department in making appropriations requests for the operations of the several institutions under its jurisdiction. Such formulas shall be developed in cooperation with the Legislative Budget Board and the Governor's Budget and Planning Office.

The Commissioner of Mental Health and Mental Retardation shall study the feasibility of combining the internal audit and community center management audit functions and if the combination is found to be feasible, may transfer such funds as may be necessary to accomplish the combination.

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[a] This is the form of presentation for all agencies' appropriation bills.

Note. HB No. 558, 66th Legislature (Regular Session), General Appropriation Bill for 1980-1981 Fiscal Years.

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TABLE 2 (cont.)

TDMHMR APPROPRIATION			EXPLANATION OF FORMAT
CONTRACT TREATMENT SERVICES AND STATE GRANTS-IN-AID			General Program Category, in this case for Community Mental Health Center
There is hereby appropriated out of the General Revenue Fund for state grants-in-aid to community centers and for contract treatment services to provide effective mental health and/or mental retardation services as authorized in House Bill No. 3, Acts of the Fifty-ninth Legislature, Regular Session, as amended, and for necessary expenses of planning and establishing community mental health centers and providing community services, such expenditures to have the prior approval of the Board of Mental Health and Mental Retardation, the following amounts:			Narrative for Community Mental Health Center
1. Center Administration	$ 10,090,940	$ 10,300,901	Program Line Items and Amounts for Each Fiscal Year for Community Mental Health Centers
2. Screening and Referral Services	4,186,179	4,333,733	
3. Outpatient Services	14,410,054	14,907,940	
4. Special Education Classes	1,375,221	1,421,123	
5. Alternate Residential and 24-Hour Residential Care	9,461,160	10,285,908	
6. Sheltered Work Training and Day/Evening Care	7,086,116	7,260,536	
Total, Contract Treatment Services and State Grants-in-Aid	$ 46,829,898	$ 48,370,141	Total for General Program Category for Community Mental Health Centers
It is the intent of the Legislature that community centers use local funds generated by them and funds granted to them out of the above appropriation to the maximum extent possible to match grants available to such centers. All such funds obtained from the federal government, except as provided in the specific provisions relating to appropriations to the Department of Human Resources, are hereby appropriated to such centers for enrichment and expansion of their mental health and mental retardation services program. None of the funds granted out of the above appropriation to a board of trustees of a community center providing mental health services, or mental retardation services, or both, may be expended, unless: a) the number of employees of the center and the salaries to be paid each of them have been approved by the Commissioner of the Texas Department of Mental Health and Mental Retardation; and b) local support funds required by the Department of Mental Health and Mental Retardation to match its grant-in-aid and all other funds made available to such center are expended according to rules, regulations and standards promulgated by the Department of Mental Health and Mental Retardation pursuant to authority contained in Section 4.01 of article 5547-204, Texas Civil Statutes. It is further provided that none of the funds appropriated hereinabove may be expended for the salary of any employee of a community center in excess of thirty eight thousand six hundred dollars ($38,600) in 1980 and forty thousand six hundred ($40,600) in 1981. It is the intent of the Legislature that the Department of Mental Health and Mental Retardation in establishing regionalization of community mental health and mental retardation programs, adhere as closely as practicable with the regional boundaries of the Councils of Governments and the Department of Health public health regions. It is the intent of the Legislature that those community Mental Health and Mental Retardation Centers serving the mentally retarded in the Dallas and Fort Worth regions maximize all resources available for the systematic and cooperative diagnosis and evaluation, referral, prescription, and follow-up of all applicants, from the respective counties, for admission to the Fort Worth State School. It is the intent of the Legislature that the Department of Mental Health and Mental Retardation in making contractual arrangements and in providing grants-in-aid for mental health services may contract directly with qualified providers in the private sector when necessary services are not provided at community Mental Health-Mental Retardation Centers in a particular region.			Narrative for Community Mental Health Centers
II-22 06-12-79 C1			

are given article numbers. The Texas Department of Mental Health and Mental Retardation falls into the Health, Welfare and Rehabilitation Agencies, which for the 1980-81 Biennium, are in Article II. The first time the appropriation appears, it is a full presentation by agency, by program, by line item. Table 2 presents two program categories under the TDMHMR agency appropriation: 1) TDMHMR - Central Office, and 2) TDMHMR - Contract Treatment Services and State Grants-in-Aid. Throughout the appropriation process, monies for CMHCs are identified as Contract Treatment Services and State Grants-in-Aid. This category is money exclusively for CMHCs.

The same format is used in presenting the entire state budget. For TDMHMR, other program categories include:

Leander Rehabilitation Facility
Supplemental Residential Services for the Mentally Retarded
  (State Schools)
Centers for Human Development (by hospital)
Texas Research Institute of Mental Sciences

The second format for presenting the appropriation is in the recapitulation of each budget article grouped by agency. Again, the TDMHMR appropriation is presented under Health, Welfare and Rehabilitation. Table 3 shows the total recapitulation for TDMHMR and some of the other agencies that are grouped in Article II.

While the money that is appropriated by the Legislature comes from revenues collected by the state, Texas has a feature of fiscal administration that complicates the allocation process. Texas has earmarked, either by constitutional or statutory provision, some revenues for particular purposes. This effectively puts the earmarked money outside of the reach of the

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TABLE 3

TDMHMR GENERAL APPROPRIATION: AS PRESENTED IN RECAPITULATION SECTION OF GENERAL APPROPRIATION BILL

TDMHMR APPROPRIATION				EXPLANATION OF FORMAT
RECAPITULATION—ARTICLE II HEALTH, WELFARE AND REHABILITATION AGENCIES[a]				Agency Group
	FISCAL YEAR 1980			
	GENERAL REVENUE	OTHER FUNDS	TOTAL	
Commission on Alcoholism	$ 1,176,028	$ 3,237,443	$ 4,413,471	Recapitulation of Appropriations for Agencies other than TDMHMR
Commission for the Blind	3,615,127	13,287,051	16,902,178	
Commission for the Deaf	212,640		212,640	
Texas Department of Health	72,769,484	62,890,631	135,660,088	
Chest Hospitals:				
Harlingen State Chest Hospital	4,068,428	110,000	4,178,428	
San Antonio State Chest Hospital	6,386,810	93,141	6,479,951	
Subtotal, Chest Hospitals	$ 10,455,238	$ 203,141	$ 10,658,379	
Total, Texas Department of Health—All Units	$ [illegible]	$ [illegible]	$ [illegible]	
Texas Health Facilities Commission	$ 268,011	536,022	$ 804,033	
Department of Mental Health and Mental Retardation:				TDMHMR Recapitulation of Appropriation by Program and Amount/Fiscal Years Recapitulation for CMHC by Amount/Fiscal Years
Central Office	7,901,739	2,904,083	10,805,822	
Centralized Food Purchase Fund	12,314,736		12,314,736	
Contract Treatment Services and State Grants-in-Aid	46,029,898		46,029,898	
Leander Rehabilitation Facility	119,412	1,000	120,412	
Supplemental Residential Services for the Mentally Retarded	384,480		384,480	
Construction Program	24,632,366		24,632,366	
Human Development Centers:				
Amarillo State Center for Human Development	1,861,392	229,557	2,090,949	
Beaumont State Center for Human Development	3,490,851	516,002	4,006,853	
El Paso State Center for Human Development	3,608,029	113,333	3,721,362	
Laredo State Center for Human Development	741,772	1,950	743,722	
Rio Grande State Center for Mental Health and Mental Retardation	1,831,429	90,294	1,921,723	
Subtotal, Department of Mental Health and Mental Retardation (Central Office, Construction, Grants and Centers)	$ [illegible]	$ [illegible]	$ [illegible]	Subtotal

Note. HB No. 558, 66th Legislature (Regular Session), General Appropriation Bill for 1980-1981 Fiscal Years.

budgetary process. An example of earmarked money is the Highway Fund. In the legislative sessions during the 1970's, over 50% of the state's revenues were earmarked funds. Community mental health center funds come out of general revenue and not from a special earmarked fund. Since many programs are funded from the General Revenue Fund, there is great demand and competition for monies from this source. Each year the number of programs/agencies increases, while the general revenue funds do not keep pace. Historically, attempts to free some of the earmarked funds have failed, and there is no reason to expect a change in the near future. This is a matter of concern for those charged with securing state grants-in-aid for CMHCs (McCleskey, 1975; Pettus & Bland, 1976).

The Legislative Budget Board

The Legislature constitutionally created the Legislative Budget Board (LBB) as one of its subsidary organs to do the initial work of preparing a statewide budget. Theoretically, in all of its work, the LBB is acting for the State Legislature. In actuality, however, as the staff of the LBB has grown and as its responsibilities have increased, the staff has taken on an identity of its own. Because of the sheer magnitude and volume of the appropriation process, the staff synthesizes the budgetary requests of the state's operating agencies, formats them, and presents the resulting budgets to the legislators. The first appropriation request a legislator sees is often the one prepared by the LBB. As the Legislature moves through the appropriation process, it is the LBB staff which is called upon to provide data and recommendations as agencies and interest groups vie for approval of their budget requests.

The underlying assumption is that the LBB staff is providing information and making recommendations that are based on systematic and scientific data, the goal of which is to fund each program to its proper level. While the budgeting process is systematic, some of the decisions made during that process are embedded in subjective values and judgements. Indeed, the Zero-Based Budget System, as part of the appropriation decision-making, is an evaluative process in which programs and requests for funds are evaluated as to cost effectiveness and efficiency. For these reasons, the LBB and its staff are crucial in the appropriation decision-making process (Benton, 1972; Handbook of Governments in Texas, 1973).

The Legislative Budget Board is a ten member ex-officio board composed of members from both houses:

Lieutenant Governor, Chairperson
Speaker of the House of Representatives, Vice-Chairperson
Chairperson of the Senate Finance Committee
Chairperson of the Senate State Affairs Committee
Two other designated members of the Senate
Chairperson of the House Committee on Appropriations
Chairperson of the House Committee on Ways and Means
Two other designated members of the House

This board selects a budget director, who along with a staff of over 60, prepares the state budget. It is the staff which wields a great deal of power in the recommendations it makes and submits to the board.

In order to fully appreciate the scope and power of the LBB, one must remember that most of the information state legislators receive from state agencies concerning the agencies' budgets (including the agency's initial request and an evaluation of its performance) is formated, synthesized and prepared by the LBB. As previously noted, the budget data prepared by the LBB and presented to the legislators is usually the first budget information the legislators receive; sometimes it is the only budget information they review. The impact of the LBB can be measured by the acceptance by the Legislature of the LBB's recommendations.

Legislative budget hearings are held by the Legislature during which state agency administrators and interested individuals and organizations may make budgetary appeals, and during which the Governor's Office submits a budget. However, the Legislature has consistently gone along with the recommendations of its own subsidiary organ, the LBB (Benton, 1972; McCleskey, 1975).

As stated earlier, the LBB is responsible for preparing a recommended General Appropriation Bill. A Zero-Based Budgeting format is used as the basis for budgetary requests and analyses. It is through this format that the LBB's decision-making process occurs and recommendations are made. The Governor's Office has adopted the LBB's recommendations for format and now also uses the ZBB (McCleskey, 1975).

During the first four steps of the budgeting process (preparation of requests, formulation of the statewide budget, legislative action, and legislative reconciliation), the LBB is collecting, organizing and evaluating data. This process is geared toward preparing its final recommended budget.

In 1963, through enactment of House Bill No. 169, the LBB was directed to establish a system of performance audits and evaluation of the state's operating agencies, departments, commissions, or institutions that receive appropriations under the General Appropriation Act. Thus, the LBB was divided in two divisions: Budget Examination and Program Evaluation. This expansion greatly increased the power and importance of the LBB, as will be discussed below.

The Budget Examination Division determines the form of:

1. the operating agency's budget request;
2. the hearing or presentation of the state's operating agency budget request;
3. the appeal, if applicable; and
4. the final budget recommendations to the Legislature.

In addition to the information that the LBB receives through the ZBB process, it also engages in other activities to assist in preparation of the budget. The LBB's Examination Division may, by Constitutional provision:

- Inspect the accounts, general or local funds, equipment and facilities of the various departments;

- Study the status of revenue dedication, special funds and priority allocation practices in order to develop, formulate and recommend to the Legislature measures necessary to provide for flexibility in allocating revenue and in preparing and executing the state budget; and

- Carry out performance audits and evaluation to provide a review of each state agency, department or commission. (Hobby, no date; Hobby, 1973)

Through its Program Evaluation Division, the LBB analyzes state agencies by preparing a Performance Report. This report includes explicit statements of the agency's statutory functions to be performed, and how these functions are being performed in terms of workload, unit cost and program output. By vesting in the LBB the evaluation of the operational efficiency and program performance of each agency, the Legislature has greatly enlarged its own powers.

As a subsidiary organ of the Legislature, the LBB is "staff" to the Legislature, and as such, takes its direction from and provides information directly to the Legislature. This can be seen especially in the programs chosen for evaluation by the Program Evaluation Division, which does not evaluate every program of every state agency. At least one program is evaluated from each state agency. Programs of the state's operating agencies which are evaluated are chosen according to legislative interest. The manner by which this interest is articulated by the Legislature and discerned by the LBB is very informal (Benton, 1972; Hobby, 1977; Hobby, 1979).

The purpose of the Performance Reports are three-fold. First, they provide information to the Legislature to assist in determining the appropriate amount of monies to be allocated from the state's budget to the agencies. Second, they serve as an audit of agency activity (performance) to assist the state and the agency in evaluating the agency. Third, they assist the Texas State Sunset Commission in determining if an agency is fulfilling its mandate. This commission's charge is to systematically and routinely review the activity of all state agencies and determine if the agency should continue to be funded.

Two Performance Reports had been prepared as of January 1980 (Legislative Budget Board, 1975; Legislative Budget Board, 1977).

The 1975 report presented each program evaluation in three parts:

1. Function category: The state agencies described their functions in terms of objectives to be accomplished. They did not relate objectives to expenditure of funds.
2. Program analysis: These programs were selected on the basis of amounts of funds appropriated and past legislative interest. Programs were evaluated by staff by relating program function to performance.
3. Efficiency analysis: The staff analyzed the efficiency of the program, but without recommendations or conclusions.

The first report emphasized the implementation of an evaluation-oriented budgeting technique (ZBB) as a budgeting technique which "strengthens the Legislator's capability to discern apparent program difficulties and the evaluation capability provides means for extensive in-depth examination" (Hobby, 1975).

The second report differed significantly from the first because the Legislature decided to use the evaluation function as an important variable in the decision-making process by which the state's operating agencies receive their level of state appropriation. In order to accomplish this objective, the second report:

1. Presented many more recommendations;
2. Incorporated program recommendations into the funding recommendations; and
3. Shifted the format emphasis from program structure to identification of essential program process for review. (Hobby, no date; Hobby, 1977; Hobby, 1979)

Each analysis in the second report contains four parts which are presented in the following order:

1. The objectives of the program;
2. The elements of the program or activity determined to be critical tasks or areas of operation necessary to meet the objectives;
3. Comments or recommendations relating to difficulties preventing the achievement of objectives; and
4. An assessment of the overall success of the program or activity in meeting its objectives, as indicated by measures selected from the reports submitted by the agency. (Hobby, no date)

The object of this format is to permit the identification of the major work tasks performed by each of the programs in the agencies reviewed. The information gathered is evaluated by the Program Evaluation Division and is passed along to the Legislature, the Governor's Office and other state agencies which use it as they carry out their various legislated duties. These reports become the major source of information about a state agency, commission or department.

Zero-Base Budgeting and its Implications for Mental Health Services to Mexican Americans

The Zero-Base Budgeting (ZBB) system was developed for use at Texas Instruments, Inc., a private, for profit corporation, in 1969 and adopted for use by the Texas State Legislature in 1973.

This system is an evaluative approach to budgeting that brings together money allocation with programmatic objective setting, program evaluation and operational decision-making. In the Texas adaptation, ZBB also fulfills many of the agency's requirements. Traditional budget making has separated budgeting and planning into two separate managerial and functional areas. In ZBB, two basic questions are addressed in addition to the issue of the amount of money requested and the amount of money awarded. The first question is, "Are the current activities efficient and effective?" After that is determined, the second question is, "Should current activities be eliminated or reduced to fund higher priority new programs or to reduce the current budget?" (Pyhrr, 1970; Lyden, 1978).

The ZBB serves as a basic framework for budgetary analysis and has three primary uses in the state allocation process. First, the process serves as a framework within which resource allocation decisions are made. Second, it also provides the format for presenting budgetary information. Third, the ZBB is a system to evaluate the probable effect of funding and programmatic decisions (Legislative Budget Board, 1978).

Each agency seeking state funds must examine each of its programs in two steps. Initially, there is an internal or inter-program examination of each program. After a method of performing an activity or program is selected, four levels of funding, along with program objectives and benefits for each level, are prepared. These four levels are called decision units. In the appropriation process followed by the CMHCs in the preparation of their 1980-1981 budget requests, each program had four decision units, each of which contained the following information:

- Level 1: Attempts to identify that critical level of funding below which the program should be discontinued because it loses its viability or effectiveness. It must not exceed 90 percent of the 1979 budgeted level of funding for the program. The percentage factor of 90 percent should be used as a general guideline for achieving a meaningful but realistic level, but may be significantly less than 90 percent.

- Level 2: If total funds requested for a program exceed the 1979 budgeted level of funding, a second level of funding should be identified that does not exceed the 1979 budgeted level of funding.

- Level 3: If funds requested for a program exceed the 1979 budgeted level of funding by 20 percent or more, a level of funding that approximates 110 percent of the 1979 budgeted funding level must be identified as a level of request.

- Level 4: A fourth level of funding will be identified in those instances when the total request for a program is equal to or exceeds 120 percent of the 1979 budgeted level (Community Services Division, 1978).

Secondly, the intra-program examination compares and ranks all programs against each other by decision units. It is during this second step that the programs undergo a process of priority ranking. Programs, funded to different levels with different outcomes, can be moved around higher or lower on an agency's priority ranking in order to arrive at a complete program/budget in a fiscal year.

Each program must be formated, using specially prepared ZBB forms. These are presented in Appendix II. Each decision unit provides the following information:

- Purpose/objective
- Description of actions (what agency will do and how)
- Costs and benefits
- Workload and performance measures

These decision units are sometimes referred to as decision packages.

The emphasis in this budgeting system is on outcome or performance in relation to cost. The measure of program success is on the number of units (that is, of people) that a program will serve during a specified period for a specified cost per unit. The quality of a program is evaluated in these terms. Outcome and performance do not address the effect of the service performed on the recipient of the service, the appropriateness of the service delivered nor the quality of the service provider (Anthony, 1977). In the language of the ZBB, outcome and performance as defined above become the values in making budgetary decisions. In a system that is based on output vis-a-vis cost, new or innovative programs may have a difficult time being funded since they may be evaluated as being overly expensive and, therefore, cost inefficient as compared to existing programs.

Services which are designed for special populations, such as Mexican Americans, may encounter these difficulties. This is not to say that culturally appropriate mental health programs for Mexican Americans will necessarily take longer to deliver or serve less clients during the same time as other programs. But these programs may have performance measures which will not compare favorably to those already in existence. For example, Burruel & Chavez (1974), in reporting on the methods of delivering mental health services to Mexican Americans by La Frontera, a successful mental health outpatient center in Tucson which serves many Mexican Americans, noted that:

> ...we attempt to deal with the current situacion by manipulating the environment, mobilizing community resources, being advocates for the client and by providing a tangible service. Also, we often deviate from conventional approaches such as length of contacts with clients--not abiding strictly with the fifty minute hour or weekly interviews, by making home visits and/or telephone calls.
>
> Many of our clients use us on a crisis to crisis (or emergency) basis, because it is very difficult for many to relate to consistent, hourly therapy sessions which would deal with strengthening their ability to cope with crisis. Instead of insisting that they engage in regular therapy, each time they contact us we try to help them learn other ways of handling their problems. This takes longer and it may not seem as effective as other approaches on the face of it, but it seems to work better with these patients, and most important, they can relate to it. (Burruel & Chavez, 1974, p. 118)

Programs which take longer to complete and serve fewer people could be evaluated as cost inefficient, no matter what the quality of care delivered and the effect of the service provided.

CHAPTER III

BUDGETARY PROCESS FOR COMMUNITY MENTAL HEALTH CENTERS IN TEXAS

Texas Department of Mental Health Mental Retardation and the Grant-in-Aid

For most CMHCs, the state grant-in-aid is the second biggest source of funds. The federal CMHC money continues to be the largest source for those CMHCs still receiving this type of funding. In theory, because there is a declining granting formula for the federal CMHC money, the state grant-in-aid should be a growing percentage of the total funds. The state grant-in-aid is intended to provide a stable base for the future funding of CMHCs after the federal "seed" money is exhausted. This places the state grant-in-aid in a pivotal position in ensuring the continued existence of CMHCs.

As was shown earlier, the federal enabling legislation for funding CMHCs has had and continues to have difficulty in conception and enactment. Piecemeal legislation is passed, almost allowed to expire and then rescued with a new bill. Requirements and regulations for eligibility are changed or modified with each new act or amendment. These difficulties not withstanding, there is an existing body of federal law, whereas Texas, has not yet passed such laws.

Texas' CMHC enabling legislation is House Bill 3 (Texas Department of Mental Health Mental Retardation, 1977). The history surrounding the passage of this Act is presented in another MHRP monograph (Brusco, 1979). In terms of the grant-in-aid process, the salient section of the Act is Article 4, which is reproduced in its entirety in Table 4. The wording of the grant-in-aid provision is vague and does not mandate any procedure or

TABLE 4

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HOUSE BILL 3: PROVISIONS FOR STATE GRANTS-IN-AID

ARTICLE 4.

STATE GRANTS-IN-AID

ARTICLE 5547-204. STATE GRANTS-IN-AID

Rules and Regulations of the Department

Sec. 4.01. (a) The Department shall prescribe such rules, regulations and standards, not inconsistent with the Constitution and laws of this State, as it considers necessary and appropriate to insure adequate provision of mental health and mental retardation services by community centers.

(b) Before any rule, regulation or standard is adopted the Department shall give notice and opportunity to interested persons to participate in the rule making.

(c) The rules, regulations and standards adopted by the Department under this Section shall be filed with the Secretary of State and shall be published and available on request from the Secretary of State.

(d) A copy of these rules shall be sent to each community center established in this State.

As amended by S. B. No. 465, Acts 61st Leg., R. S., 1969, effective September 1, 1969.

Plan

Sec. 4.02. As soon as possible after its establishment the board of trustees shall submit to the Department:

(1) a copy of the contract between the participating local agencies, if applicable;

(2) a plan within the projected financial, physical and personnel resources of the region to be served to develop and make available to the residents of the region an effective mental health or mental retardation services program, or both, through a community center or centers.

As amended by S. B. No. 465, Acts 61st Leg., R. S., 1969, effective September 1, 1969.

Eligibility for Grants-in-Aid

Sec. 4.03. A community center is eligible to receive State grants-in-aid if it qualifies according to the rules and regulations of the Department. It is specifically provided, however, that the Department may require that such grants of State funds be matched by local support in such proportions and amounts as may be determined by the Department. For the purpose of calculating the local share of the operating costs of a community center, patient fee income, services and facilities contributed by local community centers may be counted as local support. To facilitate the administration of such funds, the Department may make periodic allocations of such grants to community centers on the basis of operating budgets submitted to it by the community centers in such form as the Department may require, but shall, periodically during the fiscal period covered by such operating budgets, make such adjustments, upward or downward, as may be necessary equitably to apportion such operating costs between the State government and the community centers.

As amended by S. B. No. 465, Acts 61st Leg., R. S., 1969, effective September 1, 1969.

Auditing Procedures

Sec. 4.04. The board of trustees of a community center, as a condition precedent to its receiving further grants under this Act, shall annually have the accounts of the center audited by a Texas certified or public accountant licensed by the Texas State Board of Public Accountancy. Such audit shall meet at least the minimum requirements as shall be, and in such form as may be, prescribed by the Department and approved by the State Auditor. A copy of each such annual audit, approved by the board of trustees of the community center, shall be filed by the community center with the Department on such date as the Department may specify. Where the board of trustees declines or refuses to approve the audit report, it shall nevertheless file with the said Department a copy of the audit report with its statement detailing its reasons for failure to approve the report. In addition to the copy furnished the Department, copies of each audit report shall be submitted to the Governor, the Legislative Budget Board and the Legislative Audit Committee. The Commissioner and the State Auditor, on behalf of the Department and the Legislative Audit Committee, respectively, shall have access to all vouchers, receipts, journals and other records as either may deem needed and appropriate for the review and analysis of audit reports.

As amended by S. B. No. 465, Acts 61st Leg., R. S., 1969, effective September 1, 1969.

S. B. No. 465, Acts 61st Leg., R. S., 1969, effective September 1, 1969, repealed Section 2.09 of H. B. No. 3.

(HOUSE BILL 3, 1977.)

formulae for the awarding of state grant-in-aid money to the CMHCs. Instead, the TDMHMR is directed to prescribe the rules, regulations and standards for the process. The Board of Trustees has over the years amended the Rules of the Commissioner in an effort to provide more guidelines to the grant-in-aid process (Gaver, 1976); (Rules of the Commissioner, 1978). (See Tables 5-7.) In essence, each amendment institutes a new formula to be used in the Community Services Division in the awarding of grant-in-aid. The issue of how the grant-in-aids are awarded is discussed in the following section.

Grant-in-aid Process

As of May 1980, the history and status surrounding the issue of state grant-in-aid was not clear. It is difficult to identify and isolate the causes for this. The reasons may lie somewhere in the vagueness of House Bill 3, but even this cannot be concluded with certainty. Suffice it to say that the procedure involved in the grant-in-aid appropriation process is fairly clear, while the decision-making aspect of the awarding of grants-in-aid is not well documented, neither for the present nor historically, and is, therefore, difficult to understand and explain.

The grant-in-aid appropriation procedure, that is the step-by-step process, is fairly straightforward. The State Legislature does not make appropriations to individual CMHCs, but rather directly to TDMHMR. Since 1978, the State Legislature has appropriated to TDMHMR funds for CMHCs in the following areas:

1. Center administration
2. Screening and referral services
3. Outpatient services
4. Special education classes
5. Alternate residential and 24-hour residential care
6. Sheltered work training and day/evening care

TABLE 5

TDMHMR GRANT-IN-AID FORMULA FOR FY 1977

AMENDMENT TO RULE 302.02.01.003

(c) GRANTS-IN-AID FOR FISCAL YEAR 1977 SHALL BE ALLOCATED TO BOARDS OF TRUSTEES IN ACCORDANCE WITH THE FOLLOWING FORMULA: THE AMOUNT RESULTING FROM THE TOTAL FUNDS BUDGETED BY A BOARD OF TRUSTEES AS OF THE BEGINNING OF FY 1976 FOR STATE GRANT-IN-AID, OTHER STATE FUNDS AND FEDERAL FUNDS MULTIPLIED BY TWELVE PERCENT PLUS 53 CENTS TIMES THE TOTAL POPULATION OF THE AREA PLUS THE AMOUNT OF STATE GRANT-IN-AID APPROVED AS OF THE BEGINNING OF FY 1976 ADJUSTED TO INCLUDE ANNUAL AMOUNT FOR SPECIAL PROJECT FUNDING. THE ABOVE FORMULA IS EXPRESSED MATHEMATICALLY IN THE FOLLOWING TERMS:

$$(X + Y + Z)A + B(P) + X$$

WHERE:

"X" MEANS THE AMOUNT OF STATE GRANT-IN-AID FOR FY 1976 BUDGETED BY A BOARD OF TRUSTEES ADJUSTED TO INCLUDE THE ANNUAL AMOUNT FOR SPECIAL PROJECT FUNDING.

"Y" MEANS THE TOTAL FUNDS BUDGETED BY A BOARD OF TRUSTEES AS OF THE BEGINNING OF FY 1976 FOR OTHER STATE FUNDS.

"Z" MEANS THE TOTAL FUNDS BUDGETED BY A BOARD OF TRUSTEES AS OF THE BEGINNING OF FY 1976 FOR OTHER STATE FUNDS.

"A" MEANS TWELVE PERCENT.

"B" MEANS 53 CENTS.

"P" MEANS TOTAL POPULATION OF THE AREA.

(Rules, 1976.)

TABLE 5 (con't)

((c) Grants-in-aid shall be allocated to Boards of Trustees as determined by the Board.)

(d) Grants-in-aid allocated to Boards of Trustees shall be matched by local support in an amount determined by the Department which shall in no case be less than ten percent (10%) nor more than thirty percent (30%) of the amount of grant-in-aid. The amount and kinds of services and facilities which may be credited to local support shall be within the discretion of the State Mental Health Authority.

(e) The Department shall determine the matching ratio within the limits specified in .003.(d) by using economic indices available which are generally relied upon to indicate the financial ability of a local community to support public services to its citizens.

Issued in Austin, Texas, on March 12, 1976.

TABLE 6

TDMHMR GRANT-IN-AID FORMULA FOR FY 1978-1979

(Biennium) AMENDMENT TO RULE 302.03.01.003

(c) GRANTS-IN-AID FOR FISCAL YEARS 1978 AND 1979 SHALL BE ALLOCATED TO BOARDS OF TRUSTEES ON THE FOLLOWING BASIS:

(1) AN AMOUNT ESTABLISHED BY THE DEPARTMENT BASED ON THE ZERO-BASED BUDGET DOCUMENTS SUBMITTED TO IT BY EACH COMMUNITY CENTER FOR EACH OF THE FOLLOWING PROGRAM CATEGORIES:

(A) CENTER ADMINISTRATION,
(B) SCREENING AND REFERRAL SERVICES,
(C) OUTPATIENT SERVICES,
(D) SPECIAL EDUCATION CLASSES,
(E) ALTERNATE RESIDENTIAL AND 24-HOUR RESIDENTIAL CARE, AND
(F) SHELTERED WORK TRAINING AND DAY/EVENING CARE.

PROVIDED, HOWEVER, THAT THE AGGREGATE AMOUNTS ESTABLISHED BY THE DEPARTMENT FOR EACH PROGRAM CATEGORY SHALL NOT EXCEED THE APPROPRIATED FUNDS FOR EACH SUCH CATEGORY.

(2) THE DEPARTMENT, AFTER CONSULTATIONS WITH COMMUNITY CENTERS DURING THE BUDGET REVIEW PROCESS, MAY ADJUST THE AMOUNT ESTABLISHED UNDER PARAGRAPH (c)(1), ABOVE. UPWARD ADJUSTMENTS MAY BE REQUESTED IN INCREMENTS OF 10% OF THE AMOUNT ESTABLISHED UNDER PARAGRAPH (c)(1), ABOVE.

(3) RIDERS IN THE APPROPRIATIONS ACT WHICH APPLY TO THE ALLOCATION OF STATE GRANTS-IN-AID TO PARTICULAR COMMUNITY CENTER BOARDS OF TRUSTEES. (Grants-in-aid for fiscal year 1977 shall be allocated to Boards of Trustees in accordance with the following formula: the amount resulting from the total funds budgeted by a

(Rules, 1977.)

TABLE 6 (con't)

Board of Trustees as of the beginning of FY 1976 for State grant-in-aid, other State funds and Federal funds multiplied by twelve percent plus 53 cents times the total population of the area plus the amount of State grant-in-aid approved as of the beginning of FY 1976 adjusted to include an annual amount for special project funding. The above formula is expressed mathematically in the following terms: $X + (X + Y + Z)A + S + B(P)$, where: "X" means the amount of State grant-in-aid for special projects, as of 9/1/75; "Y" means the total funds budgeted by a Board of Trustees as of the beginning of FY 1976 for other State funds: "Z" means the total funds budgeted by a Board of Trustees as of the beginning of FY 1976 for Federal funds; "A" means twelve percent; "S" means FY 1976 State grant-in-aid budgeted for Special Projects as of 9/1/75 multiplied by 112%; "B" means 53 cents; "P" means total population of the area.)

Issued in Austin, Texas, on June 15, 1977.

TABLE 7

TDMHMR GRANT-IN-AID FORMULA FOR FY 1980-1981 (Biennium) AMENDMENT TO RULE 302.03.01.003

(c) GRANTS-IN-AID FOR FISCAL YEARS 1980 (1978) and 1981 (1979) SHALL BE ALLOCATED TO BOARDS OF TRUSTEES ON THE FOLLOWING BASIS:

(1) AN AMOUNT ESTABLISHED BY THE DEPARTMENT BASED ON THE ZERO-BASED DOCUMENTS SUBMITTED TO IT BY EACH COMMUNITY CENTER FOR EACH OF THE FOLLOWING PROGRAM CATEGORIES:

(A) CENTER ADMINISTRATION,
(B) SCREENING AND REFERRAL SERVICES,
(C) OUTPATIENT SERVICES,
(D) SPECIAL EDUCATION SERVICES,
(E) ALTERNATE RESIDENTIAL AND 24-HOUR RESIDENTIAL CARE, AND
(F) SHELTERED WORK TRAINING AND DAY/EVENING CARE; PROVIDED.

HOWEVER, THAT THE AGGREGATE AMOUNTS ESTABLISHED BY THE DEPARTMENT FOR EACH PROGRAM CATEGORY SHALL NOT EXCEED THE APPROPRIATED FUNDS FOR EACH SUCH CATEGORY.

(2) THE DEPARTMENT, AFTER CONSULTATIONS WITH COMMUNITY CENTERS DURING THE BUDGET REVIEW PROCESS, MAY ADJUST THE AMOUNT ESTABLISHED UNDER PARAGRAPH (c) (1), ABOVE. UPWARD ADJUSTMENTS MAY BE REQUESTED IN INCREMENTS OF 10% OF THE AMOUNT ESTABLISHED UNDER PARAGRAPH (a) (1), ABOVE.

(3) RIDERS IN THE APPROPRIATIONS ACT WHICH APPLY TO THE ALLOCATION OF STATE GRANTS-IN-AID TO PARTICULAR COMMUNITY CENTER BOARDS OF TRUSTEES.

(d) - (f) (no change)

Issued in Austin, Texas, on May 29, 1979.

(Rules, 1979)

The Community Services Division subsequently awards to each center one grant-in-aid, drawing money from each of these six areas. This procedure is clear and, as noted in an earlier section, the CMHCs are well guided through the steps of the appropriation process by directories, manuals and timelines set out by the LBB and TDMHMR.

Of the CMHC staff interviewed to date, all understand the process involved in the awarding of the grant-in-aid. Some feel the process is very complicated and time consuming, but these are comments commonly heard with regard to any budgeting process. Many feel that the ZBB process compounds these problems, and they would like to return to a more traditional budget preparation process (Mental Health Research Project, 1980).

Awarding Grants-in-aid

It is not possible to separate definitely the process of applying for grants-in-aid from the decision-making process of awarding specific grants-in-aid to the centers. What was presented in the previous section was the step-by-step process or mechanics of the grant-in-aid. As noted earlier, embedded in the ZBB process are subjective values and judgments which can have a major impact on the type of program funded and the amount awarded.

While the ZBB procedure may become an issue for those seeking to ensure a system of appropriate mental health services for Mexican Americans in Texas, another important issue centers around how the Community Services Division of TDMHMR decides how much grant-in-aid monies each CMHC receives. Since the passage of House Bill 3, the decision-making that goes into the awarding of state grants-in-aid is not clearly documented (Testimony, 1979). There are written formulae which purport to serve as the decision-making guide for awarding the grants-in-aid.

Over the years, the formulae for awarding grants-in-aid has changed, each change being amended to the Rules of the Commissioner (Texas Department of Mental Health Mental Retardation, 1978). Initially, a per capita award, plus some additional monies, were awarded. The Mental Health Research Project was not able to obtain documentation of this formula as of May 1980. However, the formula and rules for three budgetary periods (FY 1977 and two bienniums, FY 1978-1979 and FY 1980-1981) are presented in Tables 5, 6 and 7. The information was obtained through the assistance of the office of the Commissioner of TDMHMR. In reality, these rules are somewhat meaningless, in that when one attempts to make the formulae apply to the amount of grants-in-aid awarded to centers for the fiscal period for which they are intended, there appears to be no computational relationship. In other words, attempts to go back and apply the formula to the grant-in-aid award of a center do not work.

The reasons for this are in part historical. When CMHCs were first forming in Texas, there was a larger pool of money available for distribution than in subsequent years when the number of centers increased. Centers which were formed soon after the passage of House Bill 3 were awarded money on a per capita basis, and each successive year centers were awarded additional money on top of the previous year's base. These increases could amount to 40%-60% more than the previous year's award. As more centers were formed, less money went to each center; however, an informal rule held that no center could receive less money than was awarded in the previous year. Interview data suggest that even as these formulae were promulgated, they were rarely used because the historical factors noted above were already in place (Mental Health Research Project, 1980).

Although attempts to relate the CMHCs' grant-in-aid awards to the grant-in-aid formula through mathematical manipulation failed, this cannot be considered decisive evidence of the formula's non-applicability. In order to gain additional information about the applicability of the formulae, seven CMHC executive directors, four CMHC executive assistants and six CMHC fiscal managers have been interviewed about the grant-in-aid award process. None knew exactly how their center's grant-in-aid amount was determined for fiscal years 1980-1981. All but two of the executive directors also stated that this applied to the previous five funding periods back to 1977. The two directors who could not respond to inquiries regarding fiscal periods prior to 1980-1981 were not in administrative positions in the CMHC system during the time periods in question. Four directors had requested the funding formula from TDMHMR and were told it was not available. All stated that the formulae are not the basis upon which award decisions are made. All of the above people interviewed suggested that subjective criteria were used widely in the award decision (Mental Health Research Project, 1980). Data are continuing to be collected by the Mental Health Research Project which are focused on this issue.

Such a situation makes it difficult to understand the grant-in-aid award decisions. From the CMHCs' point of view it does not provide a stable base on which they can project the amount of grant-in-aid award. Furthermore, it is almost impossible to examine the awarding of the grants-in-aid in terms of equity. The lack of clarity and documentation in the award procedure and the apparent reliance on subjective criteria seem to run counter to the attempts of the LBB to establish accountability, orderliness and objective standards in the state's appropriation process.

On February 8, 1980, the newly formed Advisory Committee on Community Mental Health and Mental Retardation Centers (CMHMRC) to the Commissioner of TDMHMR held its first operational meeting. At the committee's request, the major order of business was a discussion of methodologies for the allocation of state grants-in-aid to CMHCs (Texas Department of Mental Health Mental Retardation, 1980). At that meeting, four alternatives for establishing a formula for awarding grants-in-aid were distributed and are presented here in Table 8. It is interesting to note the predominance of subjective criteria proposed in alternative I. As of May 1980, those alternatives were being circulated throughout the CMHC system and state bureaucracy for comments.

Additional Sources of State Funds

CMHCs are eligible to receive state funds from a number of sources in addition to the TDMHMR grants-in-aid. Centers are under no restrictions in applying for these state monies. Possible sources include the Texas Commission on Alcoholism, the Texas Department of Community Affairs, the Texas Rehabilitation Commission and the Commission for the Blind. Eligibility and programmatic requirements vary from source to source.

The funds a center receives from state agencies and commissions are recorded and reported by a center when it submits its budget request to TDMHMR. Centers apply for non grant-in-aid state money during the early stages of the appropriation process. Monies received from all state sources are counted together for meeting the local match required for the receipt of certain federal funds.

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TABLE 8

FOUR ALTERNATIVES UNDER CONSIDERATION FOR THE AWARDING OF STATE GRANTS-IN-AID TO CMHC IN TEXAS, FEBRUARY 1980

Alternative I. Submitted by Community Services Division, TDMHMR

This alternative would be consistent with the current Rules of the Commissioner for FY 1980 and FY 1981 (copy attached) with some innovations regarding how the decisions are made on prioritizing the ZBB program decision packages between and among the 30 Community MHMR Centers.

I. The prioritization process would take into consideration the following quantitative and qualitative factors:

A. Quantitative Factors (Objective)

1. General population of service area (size and density).
2. Size of target population to be addressed by this program.
3. Projected impact on the same target population served by State Schools and State Hospitals.
4. Number of clients served by this program historically.
5. Estimated cost per unit of service.
6. Documented demand for the service (identified persons waiting for the service or persons who would not be served if the program was not funded).
7. Utilization of existing services.

B. Qualitative factors (Subjective)

1. Center's track record on performance.
2. Center's estimated ability to develop and implement new programs within the time frame specified.
3. Probability of Center's ability to obtain a Certificate of Need from the Texas Health Facilities Commission.

(CMHMRC Memo, 1980.)

4. Apparent availability of needed program support services either by the Center or other agencies in the community.
5. Knowledge of currently operating programs and the advisability of maintaining those programs.
6. Special problems of individual Centers that may have had a temporary impact on ability to perform or perhaps some impending circumstance which will impact future performance.
7. Consideration of how local and Federal funds are being utilized (Is the community sharing the cost on a partnership basis between local, State and Federal government?).
8. Consideration of the amount of Center's reserve funds.
9. Economic conditions in the service areas.
10. Other governmental agencies providing MHMR services in the service areas (especially TDMHMR facilities).

II. The summary rankings by level of request would be submitted to the Legislative Budget Board and the Governor's Budget and Planning Office by program category (or by appropriation category) and by each ZBB level (Level I, Level II, Level III, etc.) for each individual Community MHMR Center.

III. The dollars would then be allocated precisely to each Center at the level appropriated by the Legislature. (TDMHMR would also attempt to obtain some flexibility regarding transfer of funds between Centers because of unpredictable circumstances.)

Note: The visibility for each Center would exist without being tied to a line item appropriation for each individual Center.

Alternative II: Maintain Formula Presently in Place as of February 1980

(c) Grants-in-aid for fiscal years 1980 (1978 and 1981 shall be allocated to boards of trustees on the following basis:

(1) An amount established by the Department based on the zero-based documents submitted to it by each community center for each of the following program categories:

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(A) Center Administration,
(B) Screening and Referral Services,
(C) Outpatient Services,
(D) Special Education Classes,
(E) Alternate Residential and 24-Hour Residential Care, and
(F) Sheltered Work Training and Day/Evening Care; provided.

However, that the aggregate amounts established by the Department for each program category shall not exceed the appropriated funds for each such category.

(2) The Department, after consultations with community centers during budget review process, may adjust the amount established under paragraph (c)(1), above. Upward adjustments may be requested in increments of 10% of the amount established under paragraph (a)(1), above.

((3) Riders in the appropriations act which apply to the allocation of State Grants-in-aid to particular community center Boards of Trustees.)

(d) - (f) (no change)

Alternative III: Submitted by TDMHMR Committee to Develop a Uniform System or Formula for the Allocation of State Grant-in-Aid to Community MHMR Centers - January 15, 1980

This option is a combination of a per capita method based on the population of the service area of each center and a reimbursement for cost of service method.

The method for each program category is as follows:

(1) Screening, Referral, and Emergency Services - This would be funded by a per capita allocation method based on the population of the area served by the center. Ninety (90) percent of G-I-A in this category would be used for this. Ten (10) percent of the funds would be allocated on a discretionary basis by the Community Services Division for special projects and equalization of funding because of special circumstances in a center area.

(2) Outpatient Clinic Services - This would be funded by a per capita allocation method based on the population of the area served by the center. Eighty (80) percent of

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G-I-A in this category would be used for this. Twenty (20) percent of the funds would be allocated on a discretionary basis by the Community Services Division for special projects and equalization of funding because of special circumstances in a center area.

(3) Special Education Services

(4) Day/Evening Care and Sheltered Workshop Services

(5) Alternate Residential Care/24-Hour Care

The above program categories would be funded on a reimbursement for services basis. Cost per unit of service eligible for reimbursement would be determined annually based on funds available not to exceed 80% of the median cost for this service within centers. This is dependent on the implementation of the cost accounting system being proposed. Centers' rate of reimbursement would be adjusted quarterly to reflect income from other sources and clients served.

(6) Center Administration - Funds for center administration would be limited to a maximum of 20% of all G-I-A funds received in the other program categories.

I. Under this option fifty percent (50%) of the funds available (appropriated) would be allocated to each Community MHMR Center on a per capita basis but at least $300,000 for each Center.

II. The remainder of the funds (the other fifty percent (50%) would be discretionary and be allocated by the Texas Board of MHMR upon the recommendation of the Commissioner (and Community Services Division) for services to specific target groups.

Alternative IV. Submitted by the Texas Councils of CMHMR Centers

A. All MHMR components within their regions develop their budgets based on their respective functions, target populations and priorities specified by TDMHMR. In this, center budgets should be determined by use of the following criteria:

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(1) Considerations of population density and economic factors of the service area;

(2) Employment of a minimum threshold of funds to permit new or small centers to service specified target populations;

(3) Consideration of unusual or unique conditions calling for special programs and funds;

(4) Consideration of other agencies providing MHMR services in the area.

B. All funds appropriated to TDMHMR components by the Legislature should be allocated to their designated recipients for the biennium. Program changes and flexibility should be achieved by employing the five-percent flexibility rider.

In summary, the conclusions and recommendations of the Texas Council supported the creations of a continuous system of MHMR care by: designating the functions, target populations, and priorities of each MHMR delivery component; regionalizing administration into four areas along HSA boundaries; and budgeting centers and institutions according to the above concepts and to the specified criteria.

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Funding Community Mental Health Centers from the Local Level

By the early 1970's, the federal government realized that the development of local funding resources for CMHCs had not occurred to the degree expected. The sources for local funding were being strained by more and more demands for allocations, while the resources were either remaining static or growing at less than the inflationary rate. Though local funding sources have not achieved the expected base funding importance envisioned by the federal government for CMHC operation, they are still a crucial funding component in the future of CMHCs. Since federal grants have begun to expire and will continue to do so without new federal legislation, the federal government must decide if the local funding sources will, in the near future, be able to to provide the necessary funds to maintain CMHCs without substantial federal money. This question was posed by the United States Senate in 1978 in a report prepared to accompany PL 95-622 (U.S. Senate, 1978). As of February 1980, the Senate had not answered the question.

As previously discussed, local funding sources are crucial to the CMHCs in obtaining funds from the state and the federal governments. In Texas, state grants-in-aid must be matched by local funds. State and local funds combined are used in the matching formulae for federal funding. In some cases, one local dollar can generate as much as 13 federal dollars. This makes the local dollar very powerful (National Institute of Mental Health, 1977).

Texas' House Bill 3 places a strong emphasis on local responsibility for providing community mental health and mental retardation services. It does not however, provide any guidelines, definitions or requirements regarding that responsibility (Statewide Citizens Committee for Mental Health Planning, 1964). Local entities have not defined their responsibility or their sponsorship of CMHCs as necessarily including any fiscal responsibility. Local governmental entities that sponsor CMHCs in Texas, such as school districts, cities, counties and councils of government, have not interpreted the responsibility for providing a stable fiscal support for the centers as part of their sponsorship of the CMHC (Board Training Project of 1976, 1977). In some instances, there is no financial support derived from sponsors.

The process by which CMHCs request and receive local funds varies from center to center. It is clear, nonetheless, that of the three budget request procedures, the most informal and idiosyncratic is at the local level. In many centers, most of the local funding process revolves around the personal contacts of the board members and/or executive director with the county commissioner or city council members. It is impossible to generalize the process for all the centers. The state's appropriation process indirectly imposes some regularity on the local process; most local governments have opted to follow the timelines used by the state. Local governments, however, usually do not follow the state's ZBB format.

Data from field interviews conducted by the Mental Health Research Project indicate commonality of experience by CMHC staff in securing local funds. In many cases, local funding has been characterized as "hard to get and hard to keep" because city and county governments and agencies do not see the CMHC as a local entity. Furthermore, historically the local governments have not provided funds for human services and do not see that as their role. Field data also indicate that CMHC staff spend more time developing and maintaining local funding sources than state or federal sources. An overriding problem with local funding is the absence of a formula for appropriating the money to CMHCs. Centers receive lump sums which are determined on no clearly discernable criteria. As of May 1980, none of the CMHC staff interviewed could see a pattern in the types of program or amount of money awarded to their center. In October 1979, requests for funding data were sent to the county judge and mayor of the city and county where each CMHC in Texas is located in an attempt to determine if there is any pattern in the type of program funded from the local level. As of May 1980, there had been no replies.

There are two types of local funding available to CMHCs: those monies tied to tax dollars and those from non-tax-derived dollars. Sources for local tax-originated dollars are the city and county governments, school districts and hospital districts. In Texas, CMHC support derived from local tax money has been a small percent of centers' source of funds (TDMHMR, 1979). In recent years, this base of support has not grown.

Of the non-tax-derived dollars, the most significant in terms of total amount are patient fees, insurance and reimbursements. Some of this money is not actually local money, but rather federal and state funds funneled through local agencies. Monies from sources such as the United Way, revenue sharing, Councils of Governments, vendor sales, loans, the local Mental Health Association and the Junior Service League constitute the remainder of the sources of local money. It should be noted that some of this money, such as revenue sharing and Model Cities, is really federal money which is passed through the local government to the CMHC.

Trends in Funding Community Mental Health Centers in Texas

When funding data for CMHCs are compiled over time, several general trends in the level and growth of source of funds become apparent. These statewide trends are compatible with national funding trends for CMHCs as discussed earlier.

The overall picture that emerges from the data presented in Chart 4 is that there has been a steady increase in the money appropriated to the Texas Department of Mental Health and Mental Retardation from 1965 to 1980. As the total appropriation for the Texas Department of Mental Health and Mental Retardation has increased, so has the total of grants-in-aid awarded to CMHCs. Chart 5 demonstrates the increase, but it does not correct for new CMHCs. The data in Table 9 draw a comparison between the total TDMHMR budget and the budget for CMHCs. The percentage of increase of the CMHCs' budget is not as great as the increase in the overall budget.

The source of funds for CMHCs is of major interest and concern to policymakers and people concerned with the future of CMHCs. Chart 6 presents data from 1971 through 1981 on the amount of funds by the source. The decline in federal funds is expected since these funds are based on a declining formula.

As of May 1980, it was not possible to project with any surety the statewide trends for future CMHC funding. As noted earlier, the state's grant-in-aid formula is currently undergoing revision. A legislatively mandated research committee, the Special Committee on Delivery of Human Services in Texas, which was formed by Senate Resolution 67, is reviewing the role and function of TDMHMR vis-a-vis the CMHCs. Funding of CMHCs is one of the issues it is addressing. This committee's report is due in September 1980.

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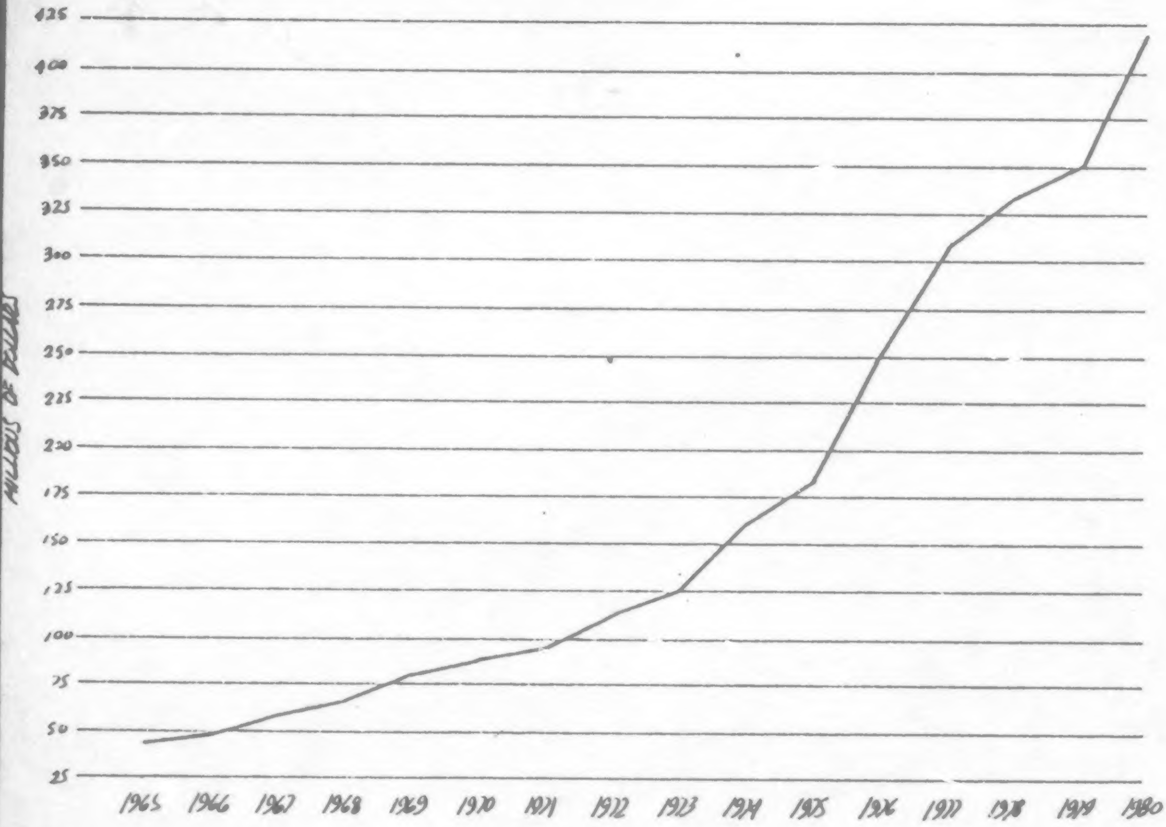
CHART 4

TOTAL APPROPRIATIONS FOR TDMHMR EXCLUDING CONSTRUCTION FUNDS



Note. This chart was prepared by the Mental Health Research Project from data obtained from the Texas Department of Mental Health Mental Retardation and the Legislative Reference Library.

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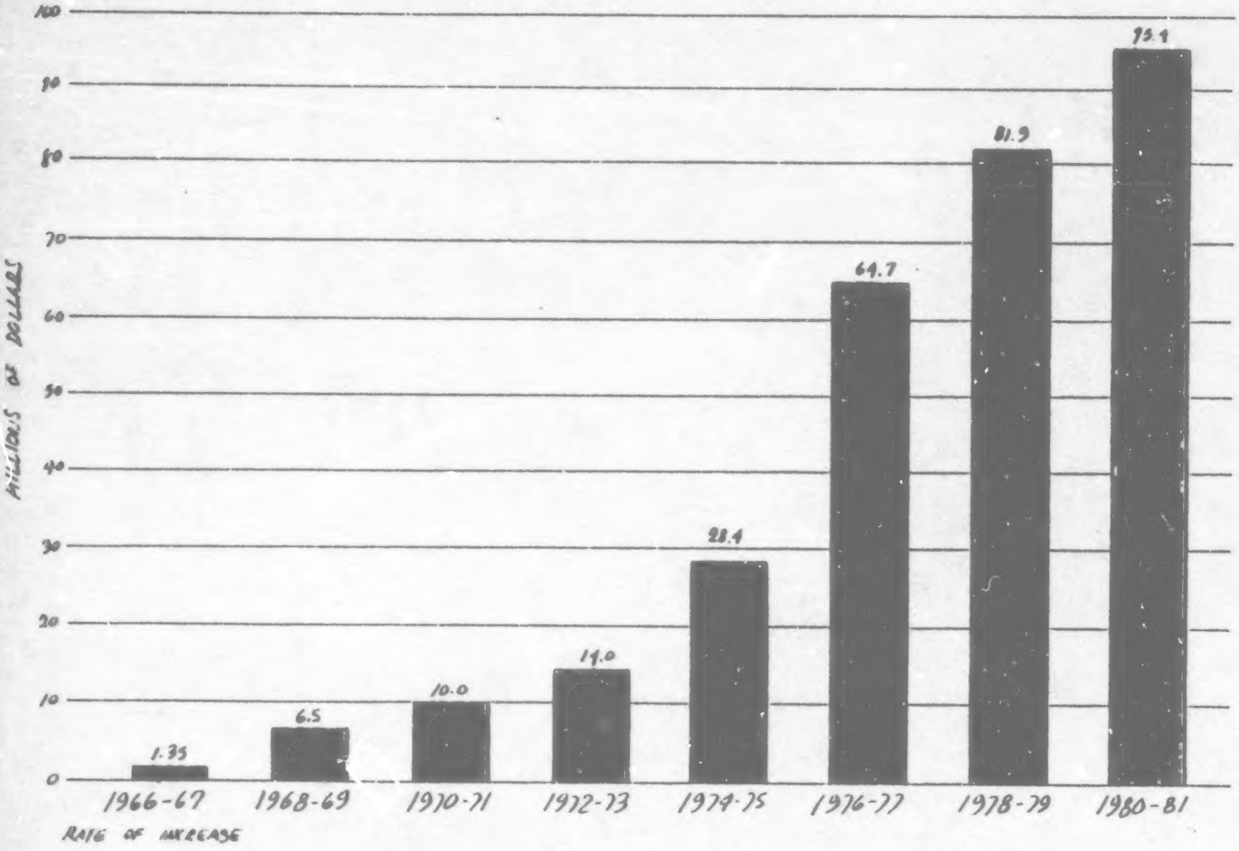
CHART 5

GENERAL REVENUE APPROPRIATIONS FOR CONTRACT TREATMENT SERVICES AND STATE GRANTS-IN-AID 1966-1981



Note. This chart was prepared by the Mental Health Research Project from data obtained from the Texas Department of Mental Health Mental Retardation and the Legislative Reference Library.

TABLE 9

PERCENT OF TDMHMR APPROPRIATION ALLOCATED TO CMHCS IN TEXAS

FY	TDMHMR APPROPRIATIONS[a]	GIA	GIA % OF TDMHMR BUDGET	SOURCES
1974	161,660,052	12,312,511	7.6%	HB 139
1975	180,419,277	16,125,021	8.9%	1973
1976	259,291,072	26,787,390	10.3%	SB 52
1977	302,836,441	37,949,660	12.5%	1975
1978	339,457,872	40,205,307	11.8%	HB 510
1979	351,013,587	41,794,006	11.9%	1977
1980	379,743,201	46,829,898	12.3%	HB 558
1981	393,568,602	48,570,141	12.3%	1979

[a] This figure does not include construction funds.

Note. This chart was prepared by the Mental Health Research Project from data obtained from the Texas Department of Mental Health Mental Retardation and the Legislative Reference Library.

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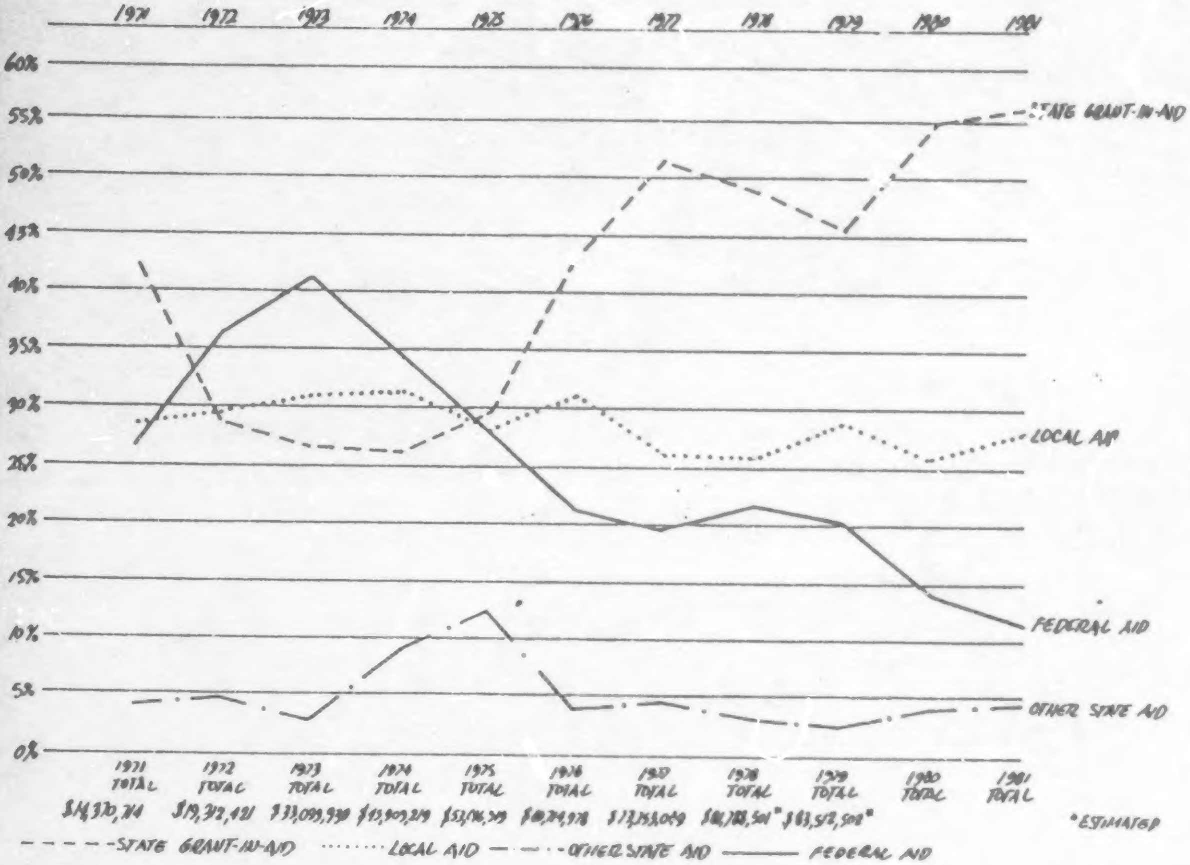
CHART 6

COMPARISON OF FINANCIAL SUPPORT BUDGETED BY CMHC BOARDS OF TRUSTEES 1971-1981



Note. This chart was prepared by the Mental Health Research Project from data obtained from the Texas Department of Mental Health Mental Retardation and the Legislative Reference Library.

CHAPTER IV

IMPLICATIONS FOR MENTAL HEALTH SERVICES TO MEXICAN AMERICANS

The preceding description of the budget allocation process presents a technical, albeit crucial, component in the exploration of the mental health service delivery system in Texas and its relationship to the needs of Mexican Americans in the state.

Funding is the life blood of a program. No matter how appropriate and necessary a program is, if it is not funded or if it is underfunded, the program can rarely reach full life. Knowledge of how the appropriation process works; where in the process the hidden subjective values come into play; what subjective values are intrinsic to the system; the access points in the system; and the formal/informal roles and power of the "actors" in the system can be the keystone in the construction and enactment of social policy.

This is not meant to imply that with the preceding information social policy and programs providing for appropriate quality mental health care for Mexican Americans are assured adoption. Many other factors must be considered. While no evidence of discrimination has been documented to date in this research, Texas' history of racial and ethnic discrimination, segregation and neglect will need to be considered. In addition, the realities of the limits of the system and the resources available must play a role in any attempt to initiate new social policy. An understanding of the appropriation process is not the sole ingredient needed to ensure adoption of social policy; it is, however, an ingredient that must be included if success is to be achieved.

In considering any initiation of policy and programs, including those focused on establishing a system of appropriate mental health care for Mexican Americans, two factors should be apparent:

1. Any proposed policy and/or programs will have to grapple with a budgeting system (ZBB) that combines program evaluation with the decision-making of budget allocation. This system is used by policymakers to reward, through funding, those programs which can document cost effectiveness. A positive value is placed on providing a stated service to a specified number of people, with a specified number of personnel within a given time period at the lowest cost. Effectiveness of the service (defined as appropriateness) and quality of the program are two issues which are at best tertiary values, if considered at all. A new program which emphasizes appropriateness and quality as first level values may have a difficult time in being funded, particularly if fewer numbers of people were served by more personnel at equal to or higher costs than in existing programs.

2. Any proposed policy and/or program will have to address the many different "actors" who make decisions in the allocation process. The pivotal roles of the Legislature and the staff of the Legislative Budget Board cannot be over-emphasized. The allocation process provides the steps to be followed and the data to be used in the decision-making within the context of those services which are mandated to be provided, but the content, or what may be funded, in large part depends upon the subjective values intrinsic in the system and in the Legislature, the LBB staff, and the bureaucrats. In large part, the system, through these "actors", must

acknowledge the need for mental health programs for special populations, including Mexican Americans. This acknowledgment creates a policy by which these programs can gain value and then initiation and implementation in the system.

The Texas Department of Mental Health and Mental Retardation, particularly the Community Services Division and the Board of Trustees, are also important "actors" in the funding process. During 1980, the role of the Community Services Division will be undergoing reconsideration; however, it may be assumed that both "actors" will be central in any future process employed for awarding grants-in-aid. These "actors" serve as agents or intermediaries between the CMHCs and the Legislature. Here, too, understanding the process is but a small part of comprehending how budget decisions are made. The priorities set by TDMHMR are based both on objective data and on the subjective values held by the staff.

What has been discussed in this monograph is the interrelationship between formal process, the hidden values of that process and the subjective values of the "actors" in that process. The study was unable to find evidence of the existence of any stated appropriation policy, procedure or mandate which incorporates the issue of the mental health needs of Texas' largest linguistic minority - Mexican Americans. Concurrently, the research did find instances of hidden subjective values within the ZBB system and the decision-making of state agencies which may have an adverse affect on establishing mental health services aimed at Mexican Americans.

Given this situation, with the research limitation it creates, the researcher is posed with a dilemma of how to proceed in exploring the possible relationship between the appropriation process for awarding grants-in-aid to CMHCs and Mexican

Americans. What follows is an exploratory approach which focuses on the question of this relationship from two perspectives.

The research approach used first involved the identification of variables that might possibly be used in the appropriation process if there was a policy in Texas that mandated specific programs for Mexican Americans, the state's largest linguistic minority. Second, variables were identified which could attempt to shed some light on the possible existence of this relationship within the budget request procedure at the CMHC level and the grant-in-aid award process the state level in TDMHMR. In addition, the variables had to:

- be applicable to all CMHCs in Texas;
- be a regular component of the CMHCs' system; or
- be in a form that would render them comparable among CMHCs.

To explore the existence of this relationship from the state level, the variable chosen was the existence of Spanish Language/Spanish Surname (SL/SS) population. The variable chosen to focus on the same issue but from the perspective of the CMHC was the existence of stated ethnic content in the decision units or packages that comprised the budget/program document (ZBB) from each center for fiscal year 1980.

Population as a Variable in Community Mental Health Center Budget Allocation

Using 1970 census data, all community mental health centers were ranked from highest to lowest according to three population counts: 1) total population, 2) non-Spanish surnamed population, and 3) Spanish surnamed population. Next, the centers were ranked from highest to lowest by two classes of funding: 1) total funds awarded from FY 1979 and 1980, and 2) TDMHMR grants-in-aid awarded from FY 1979 and 1980. The rankings are presented in Table 10 along with the actual dollar amounts awarded to each center. The data were reviewed to see if any pattern was discernable or any type of relationship existed between total population and/or Spanish Language/Spanish Surnamed population and amount of funds.

The CMHCs seem to fall into three clusters of high total population centers to low total population centers. (See Table 11.) The CMHC also falls into comparable clusters based on the total amount of funds received.

For the years described in Table 10, the centers with the greatest total population, Harris, Dallas and Bexar, are always the top three in amount of funds received. Wichita Falls, Central Plains, Central Texas, Pecan Valley, North East Texas and Concho Valley, centers from the lowest total population groups, consistently rank at the bottom of amount of funds received. In the middle level of funding, the range is broader and there is somewhat more movement of the rank of the centers for the two funding periods. However, most centers usually stay within two or three funding rankings of their population rank. For example, Gulf Coast is ninth in population rank, and in total dollars awarded for FY 1979 is eighth; in total dollars for FY 1980 is seventh; is 13th in grant-in-aid for FY 1979, and seventh in grant-in-aid for FY 1980. This pattern seems to reflect the initial per capita method by which TDMHMR grants-in-aid were allocated.

As is noted in Table 11, those centers with a high SL/SS population roughly follow the total population clustering in the greatest population areas. The three centers with large SL/SS population (Tropical, El Paso, Bexar) are also centers with a

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TABLE 10

COMPARISON OF POPULATIONS AND FUNDING LEVELS AT CMHCS IN TEXAS

CENTRAL RANK	POPULATION CHARACTERISTICS 1970			TOTAL FUNDS 1979 & 1980				TDMHMR GRANT - IN - AID 1979 & 1980			
	Total Pop. (ranked)	Non-Spanish Surnamed (ranked)	Spanish Surnamed (ranked)	FY 1979 (ranked)	Dollar Amount FY 1979	FY 1980 (ranked)	Dollar Amount FY 1980	FY 1979 (ranked)	Dollar Amount FY 1979	FY 1980 (ranked)	Dollar Amount FY 1980
1	HARRIS	BEXAR	TROP TX	HARRIS	14,088,046	HARRIS	16,108,475	HARRIS	783,757	HARRIS	7,784,265
2	DALLAS	TROP TX	EL PASO	DALLAS	11,391,638	DALLAS	11,767,149	DALLAS	335,770	DALLAS	6,110,538
3	BEXAR	EL PASO	BEXAR	BEXAR	8,644,706	BEXAR	9,534,720	BEXAR	229,148	BEXAR	3,593,326
4	TRINITY	HARRIS	NUECES	AUSTIN	5,330,018	AUSTIN	5,484,376	HEART TX	168,740	TRINITY	3,136,074
5	TROP TX	NUECES	GULF BEND	TRINITY	4,733,658	TRINITY	5,366,445	NUECES	157,906	AUSTIN	2,309,366
6	EL PASO	DALLAS	CEN PLAINS	NUECES	3,521,729	TROPICAL	3,717,573	TRINITY	130,124	NUECES	1,843,584
7	AUSTIN	AUSTIN	LUBBOCK	HEART TX	3,298,962	GULF COAST	3,694,323	EAST TX	118,366	GULF COAST	1,711,104
8	SE TEXAS	LUBBOCK	CONCHO	GULF COAST	3,131,592	NUECES	3,629,590	EL PASO	113,264	EL PASO	1,676,626
9	GULF COAST	TRINITY	AUSTIN	CENTRAL CO	3,120, 565	DEEP E TX	3,061,505	TROPICAL	104,512	SE TX	1,467,109
10	AMARILLO	GULF BEND	PERMIAN	DEEP EAST	3,093,411	HEART TX	2,973,044	PERMIAN	83,855	TROPICAL	1,443,442
11	DEEP EAST	GULF COAST	GULF COAST	TROP TX	2,773,212	EL PASO	2,816,353	AMARILLO	81,157	AMARILLO	1,361,268
12	LUBBOCK	CEN PLAINS	HARRIS	LUBBOCK	2,719,090	CENTRAL CO	2,715,527	AUSTIN	63,343	HEART TX	1,259,433
13	CENTRAL CO	AMARILLO	ABILENE	EL PASO	2,337,569	EAST TX	2,522,575	GULF COAST	58,555	LUBBOCK	1,241,788
14	NUECES	PERMIAN	CENTRAL CO	SABINE	1,992,550	SE TX	2,514,093	CENTRAL TX	57,857	CENTRAL CO	1,201,290
15	SABINE	CENTRAL CO	CEN TEXAS	SE TEXAS	1,895,184	SABINE	2,376,399	LUBBOCK	57,754	DEEP E TX	1,189,159
16	HEART TX	CONCHO	BRAZOS	AMARILLO	1,890,983	PERMIAN	2,269,525	CENTRAL CO	57,402	PERMIAN	1,019,528
17	EAST TEXAS	SE TEXAS	AMARILLO	PERMIAN	1,880,145	AMARILLO	2,072,580	DEEP E TX	56,326	EAST TX	1,009,981
18	PERMIAN	HEART TX	DALLAS	EAST TEXAS	1,783,785	ABILENE	2,034,360	SE TX	53,231	BRAZOS	914,822
19	BRAZOS	BRAZOS	HEART TX	ABILENE	1,605,855	TEXOMA	1,864,724	ABILENE	44,702	ABILENE	791,011
20	GULF BEND	ABILENE	TRINITY	TEXOMA	1,597,473	CENTRAL TX	1,775,656	CEN PLAINS	37,383	WICHITA	738,594
21	ABILENE	CEN TEXAS	WICHITA	CEN TEXAS	1,578,916	WICHITA	1,658,913	CONCHO	37,715	CEN PLAINS	708,916
22	TEXOMA	WICHITA	SE TEXAS	CEN PLAINS	1,446,744	BRAZOS	1,584,085	WICHITA	36,413	SABINE	690,714
23	WICHITA	DEEP EAST	PECAN VAL	WICHITA	1,442,868	GULF BEND	1,495,519	TEXOMA	23,834	GULF BEND	680,884
24	CEN PLAINS	SABINE	DEEP EAST	BRAZOS	1,129,113	CEN PLAINS	1,126,185	SABINE	18,094	TEXOMA	580,911
25	CEN TEXAS	EAST TEXAS	EAST TEXAS	GULF BEND	1,099,674	CONCHO	1,050,000	NE TX	12,929	NE TX	566,134
26	PECAN VAL	PECAN VAL	TEXOMA	NE TEXAS	799,928	NE TEXAS	886,552	GULF BEND	10,981	CONCHO	532,925
27	NE TEXAS	TEXOMA	SABINE	CONCHO	789,695	CENTRAL	481,822	PECAN VAL	5,000	CENTRAL	504,510
28	CONCHO	NE TEXAS	NE TEXAS	PECAN VAL	388,565	PECAN VAL	538,936	BRAZOS	3,968	PECAN VAL	309,784

large total population. The clustering is not as clear in the medium and low population clusters. Table 11 clearly shows that the three centers with the largest concentration of SL/SS population are also within the cluster of CMHCs with large total populations.

Conclusions deduced from these data are at best tentative and should not be overdrawn. Other factors such as the date the CMHC was established or special local matching arrangement may explain some of the levels of funding. Generally, however, there seems to be a relationship between total population and level of funding. This is compatible with the initial per capita formula used by TDMHMR in awarding grants-in-aid and the informally evolved policy of not funding a CMHC at a lower level than the previous year's level. There is no evidence in this pattern that any other variable but total population has a relationship to the level of funding. For those CMHCs with high SL/SS populations that are receiving higher levels of funding, it can be concluded that this is because these CMHCs also have a high total population. By this, we mean that there is a coincidence of areas which have a high level of funding and also have a high number of Spanish surnamed population. In essence, high level funding for CMHCs with larger SL/SS populations appears to be a byproduct, not a policy goal, of TDMHMR or the State Legislature. This conclusion is compatible with the research completed for this monograph which has not found evidence of state policy which specifically addresses the mental health needs of Mexican Americans.

The issue is a crucial one, for two reasons. First, there are those who point to the levels of funding received by CMHCs such as Tropical, El Paso and Bexar, to prove that areas of the state with large Mexican American populations are receiving high levels of funding. They jump to the conclusion that the SL/SS population is a causal factor in the funding formula. The data presented here do not substantiate that conclusion.

TABLE 11

POPULATION CLUSTERS BASED ON TOTAL POPULATION OF CMHC CATCHMENT AREAS, FROM 1970 CENSUS

CLUSTER GROUP 1 High	CLUSTER GROUP 2 Medium	CLUSTER GROUP 3 Low
MHMR Authority of Harris County, Houston	MHMR of Southeast Texas, Beaumont	Brazos Valley MHMR Center, Bryan
Dallas County MHMR, Dallas	Gulf Coast Regional MHMR Center, Galveston	Gulf Bend MHMR Center, Victoria[5]
Bexar County MHMR Center, San Antonio[3]	Amarillo MHMR Regional Center, Amarillo	Abilene Regional MHMR Center, Abilene
Trinity Valley MHMR Authority, Fort Worth	Deep East Texas Regional MHMR Services, Lufkin	Texoma Regional MHMR Center, Denison
Tropical Texas Center for MHMR, Edinburg[1]	Lubbock Regional MHMR Center, Lubbock[7]	Wichita Falls Community MHMR Center, Wichita Falls
El Paso Center for MHMR Services, El Paso[2]	Central Counties Center for MHMR Services, Temple	Central Plains Comprehensiv CMHMR Center, Plainview[6]
MHMR Center - Austin-Travis County, Austin[9]	Nueces County MHMR Community Center, Corpus Christi[4]	Central Texas MHMR Center, Brownwood
	Sabine Valley Regional MHMR Center, Longview	Pecan Valley MHMR Region, Stephenville
	Heart of Texas Region MHMR Center, Waco	Northeast Texas MHMR Center, Texarkana
	MHMR Regional Center of East Texas, Tyler	Concho Valley Center for Human Development, San Angelo[8]
	Permian Basin Community Centers for MH and MR, Midland[10]	

[a] 1-10 indicates the ten catchment areas with the greatest Spanish Language/Spanish Surnamed population.

Note. The source for this information is from the Community Services Division, Texas Department of Mental Health Mental Retardation, 1970 Census and Mental Health Research Project.

Second, the issue of the possible affect this pattern of funding could have on programs for Mexican Americans is also important. Federal CMHC laws mandate programs that specifically and fully serve linguistic minorities. However, Texas has not adopted a similar policy. One result of this is that concentrations of SL/SS populations are not a variable in the funding formula. This could adversely affect the level of funding that centers with special populations, including Mexican Americans, receive.

Stated Ethnic Program Content as a Variable in Community Mental Health Center Budget Requests

The preceding inquiry focuses on the possible relationship of SL/SS population and level of CMHC funding, with the emphasis placed on the state level perspective. Even though no relationship could be found and a tentative conclusion was reached that the SL/SS population is not used as a funding variable, there are other areas of the funding process which can be explored.

Community mental health centers prepare their own budget requests which are submitted to the Community Services Division of TDMHMR. In following the ZBB format, the CMHCs prepare a written description for each program. Each CMHC indicates in the narrative description of each program information which is required by the various state agencies involved in the appropriation process, and that the center evaluates as "carrying weight" or being of positive value to the TDMHMR bureaucrats who make grant-in-aid award decisions. The space allotted for program description is limited - approximately ½ page. Therefore, the CMHC staff carefully must choose to include the information they decide will work best toward getting the program funded.

The monograph has already established that there exists no policy or requirements for mental health programs for Mexican Americans. In order to determine if the CMHCs included any program description related to services to Mexican Americans in their budget request, a simple content analysis was designed. This content analysis was used to identify the mental health programs offered in FY 1980 by CMHCs which had a cultural component stated in the program's description, as found in each center's budget document. All the FY 1980 budgets for the state's CMHCs were collected. The LBB system requires that each program be presented separately with each using the same forms. These forms are found in Appendix II. By reading through each center's budget, one will have an almost complete roster of all the programs being offered for a fiscal year at all the CMHCs.

A broad operational definition of a cultural component included any program which mentioned:

- serving an ethnic or cultural minority, either as a community or an individual;
- an ethnic service provided;
- a service delivered in Spanish;
- minority values or roles as program issues or goals; and/or
- language other than English, as a program target or variable.

Each program was then reviewed, paying special attention to the program material presented in the Narrative Description, Form B/22.

All of the programs (a total of 693) offered by CMHCs in January 1980, the start of FY 1980, were read and any cultural component, as defined above, was noted. Of the 693 programs reviewed, 15 programs were identified as having a cultural component. This is approximately 2.2% of the total number of CMHC programs. These data are presented in Table 12. Those centers which had a cultural component in their programs' narrative were Amarillo, Austin, Bexar, Central Counties, Lubbock, Nueces and Tropical Texas. Most of the programs having a cultural component were from the Nueces County MHMR Center which had five programs and the Bexar County CMHC which also had five. It must be noted that the definition used identified those programs which cited Spanish speaking or Mexican American populations as the population group, but did not necessarily note any culturally or ethnically specific service.

While one again must exercise caution in drawing a conclusion, these data are significant in understanding the kinds of program descriptions that centers identify as important enough to include in the budget document. Additionally, these data indicate the types of program descriptions the centers might evaluate as "carrying weight" with the TDMHMR Community Services Division in obtaining approval of their grant-in-aid. This approval is vital since so many CMHCs with so many programs are vying for approval (that is, a budget award). On the basis of these data, a tentative conclusion is proposed that bilingual/bicultural components in CMHC programs are not viewed by the CMHCs as a positive value or as "carrying weight" in the decision-making process used by TDMHMR in awarding grants-in-aid.

Conclusion

This monograph raises many issues which need to be pursued in future research. It has been established that intricate, often obscure budgeting procedures exist and must be understood

TABLE 12

COMPARISON OF THE TOTAL NUMBER OF PROGRAMS OFFERED BY CMHCS IN TEXAS AND PROGRAMS WITH A STATED ETHNIC COMPONENT FOR FY 1980

CENTER	Total # programs FY 1980	Total # programs w/stated ethnic component
ABILENE	25	0
AMARILLO	23	1
AUSTIN	31	1
BEXAR	54	5
BRAZOS VALLEY	6	0
CENTRAL COUNTIES	29	1
CENTRAL PLAINS	12	0
CENTRAL TEXAS	21	0
DALLAS	59	0
DEEP EAST TEXAS	38	0
EAST TEXAS	23	0
EL PASO	20	0
WEST TEXAS	10	0
GULF BEND	14	0
GULF COAST	18	0
HARRIS	79	0
HEART OF TEXAS	26	0
LUBBOCK	24	1
NORTHEAST TEXAS	16	0
NUECES	22	5
PECAN VALLEY	11	0
PERMIAN BASIN	23	0
SABINE VALLEY	10	0
SOUTHEAST TEXAS	19	0
TEXOMA	11	0
TRINITY VALLEY	42	0
TROPICAL TEXAS	17	1
WICHITA FALLS	10	0
TOTAL	693	15 or 2.2%

in order to implement programmatic change. One must not overlook the importance of subjective values in the outwardly empirical budgeting process. The "actors" and process have been identified, and some initial work has been presented documenting some values that do not appear to be part of the decision-making process. Also no evidence could be found of policy within the state's appropriation procedure to provide programs and funds specifically to meet the needs of Mexican Americans. Furthermore, explorations into a possible informal relationship between Mexican American population and the CMHCs' levels of funding were not conclusive. While more questions should be researched, this study has shown that the existence of and needs of the state's Mexican Americans do not appear to be a component in any phase of the state's appropriation process.

Research must now identify the variables and values that need to be included in budgeting systems to insure that all populations, including special linguistic populations, are adequately and appropriately served.

APPENDIX I

The following chart reflects the funding mechanism of the community mental health legislation from 47 states. These data are current through the 1978 legislative session. The first state to enact this type of legislation was New York in 1959, which preceded the federal legislation by nine years. Fourteen other states had legislation before the passage of the National Community Mental Health Centers Act of 1965.

The data which follow present the states' laws covering the state funding of community mental health centers. Mechanisms for providing state funds to the community mental health centers include grants-in-aid, purchase of services, contracts or a combination of these sources. The various states have different formulae and ranges for awarding matching funds. There also is a wide range of eligibility requirements.

APPENDIX I

BEST COPY AVAILABLE

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Alaska	(1975)	The Department of Health and Social Services	Grants	Seventy-five percent; 90% to poverty areas.	City, borough, or other political subdivision of the state; Non-profit corporation; or a combination of these.	Regulations are to specify types of service and programs to be eligible for support; but shall include mental retardation, drug abuse. alcoholism, and comprehensive mental health services, programs.
Arkansas	(1967)	Arkansas State Hospital, Division of Mental Health	Purchase of Services	Fifty cents per capita.	State boards and agencies; community mental health clinics or centers.	Outpatient, diagnostic, treatment services; collaborative and cooperative services for prevention and treatment of mental illness; consultative services; ' informational and educational services; study and training activities.

APPENDIX I (con't)

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STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
California	(1957)	Department of Health, Treatment Services Division, Mental Health Program	Grants	Ninety percent; 100% for services to persons adjudicated, not guilty by reason of insanity, incompetent to stand trail, or mentally disordered offenders.	Counties, cities over 50,000 or combinations thereof; local health districts.	Comprehensive range of services; for alcoholics and drug addicts. Minimum of two. One must be inpatient, outpatient, partial care, or diagnostic services.
Colorado	(1963)	Department of Institutions	Purchase of services	Sixty percent for services under (A), not to exceed $.60 per capita. Ninety percent of services under (B), if appropriations permit.	Clinics, community mental health centers, general or psychiatric hospitals, and other approved agencies.	(A) Consultative services; collaborative and cooperative services for prevention and treatment of mental illness; information and educational services; and outpatient services. (B) Inpatient, partial hospitalization, and emergency services.
Connecticut	(1955)	Department of Mental Health	Grants and contracts	A per capita formula developed by the Commissioner of Mental Health.	Any nonprofit organization.	Inpatient; outpatient; partial hospitalization; diagnostic; treatment and screening; aftercare and rehabilitation; prevention; education;

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STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Connecticut (con't)						consultation; and emergency services; research; evaluation; training; services to the courts; and alcohol and drug abuse treatment services.
Florida	(1970)	Department of Health and Rehabilitative Services Division of Mental Health	Contracts	Seventy-five percent	Nonprofit corporations.	Inpatient; outpatient; partial hospitalization; 24-hour emergency services; consultation and education; information services to the general public; diagnostic; rehabilitation including vocational and educational; precare and aftercare community services; training and research evaluation. Mental retardation and developmental disabilities services including: daycare services; respite care services; medical care; recreation; physical therapy; training; social services parent training and other habilitative and rehabilitative services.

APPENDIX I (con't)

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STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Georgia	(1976)	Director of the Division of Mental Retardation, Department of Human Resources	Grants and contracts.	Unspecified in the law.	Contracts for services with: public or private hospitals; hospital authorities; medical schools; training and educational institutions; state departments, agencies, governments county or municipal governments; any person; public or private partnerships; corporations or associations; or the Federal government. Grants to county boards to implement CMHMR programs.	Outpatient services during day and early evening hour including diagnostic and evaluation services; day training and work activity centers for the retarded; residential services for patients where necessary; emergency services including crisis interventio and counseling; consultation, education and training services; and all other services added to the state program by the Division of Mental Health and Mental Retardation.
Idaho	(1961)	State Board of Health, Division of Mental Health	Contracts	Unspecified in the law.	Public and private agencies and non-profit corporations.	Inpatient; outpatient; partial hospitalization; 24-hour emergency service; consultation and education diagnostic; rehabilitative precare and post-care; training; and research and evaluation.

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Illinois	(1961)	Department of Mental Health and Developmental Disabilities	Grants	Unspecified in the law.	Counties; cities; villages; towns; public health districts; county health departments; school districts; or combinations thereof.	Psychiatric or clinical; training and other mental health programs and services, including these for the alcoholic, the drug addicted, and the mentally retarded.
Indiana	(1955)	Department of Health	Grants	Not to exceed 50%	Outpatient department of general hospitals or psychiatric clinics.	Outpatient; consultation; education; training; follow-up services; and mental retardation.
Kansas	(1975)	Department of Social and Rehabilitation Services	Contracts	Not to exceed 50%.	Counties or combination of counties, and non-profit corporations.	Inpatient; outpatient; diagnostic and treatment services; rehabilitation; consultation; in-service training; education, information, research and mental retardation services.

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Kentucky	(1964)	Department for Human Resources, Bureau for Health Services	Grants	Not to exceed 50%.	Combinations of cities or counties and non-profit corporations.	Must provide at least 4 of the following; inpatient; outpatient; partial hospitalization; emergency; and consultation and education for the mentally ill, drug abusers and all age groups including children and the elderly; inpatient; outpatient; partial hospitalization, emergency; consultation and education; and mental retardation services for the mentally retarded. Collaborative and cooperative services with public health and other groups for prevention of mental illness, mental retardation, and other psychiatric disabilities; information and education to the general public, lay, and professional groups, consultative; inpatient diagnostic and treatment; rehabilitative and detoxification.

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Louisiana	(1964)	State Department of Hospitals	Contracts	Not to exceed 75%.	Local voluntary associations; non-profit corporations; police; juries; school boards; municipalities; and other public agencies.	Mental health centers, guidance centers, including mental retardation services.
Maine	(1959)	Department of Mental Health and Corrections	Grants	Not to exceed 75%.	Municipalities; counties; school districts; health districts; other units of government and non-profit organizations.	Diagnostic and treatment services; consultation and education; and mental retardation.
Maryland	(1966)	Department of Health and Mental Hygiene	Grants or Contracts	Unspecified in the law.	Counties and public non-profit organizations.	Inpatient; outpatient; partial care services, 24-hour emergency; consultation and education; rehabilitation; research, training and aftercare services.

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Massachusetts	(1966)	Department of Mental Health	Direct operation or by contract	Unspecified in the law.	State operated facilities, other public and private facilities.	Comprehensive range including: mental retardation and alcoholism treatment.
Michigan	(1963)	Department of Mental Health	Grants	Ninety percent.	Cities of over 500,000; counties or combinations of counties.	Inpatient; outpatient; prevention; information, education; consultation; aftercare; 24-hour crisis intervention, day program and activity services; and rehabilitation services for the mentally retarded.
Minnesota	(1957)	Commissioner of Public Welfare	Grants and/or contracts	Not to exceed 50% and not to exceed 75% in distressed areas.	Cities; counties; towns; villages; and combinations thereof.	Outpatient; prevention; education; information; rehabilitation; mental retardation; drug abuse and alcoholism treatment.

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Missouri	(1978)	Department of Mental Health	Contracts	Unspecified in the law.	County or combination of counties.	Comprehensive including: inpatient; outpatient; day care and other partial hospitalization services; emergency; diagnostic and treatment; liaison and follow-up; consultation and education; rehabilitation; prevention; screening; follow-up care; transitional living; alcoholism and alcohol abuse prevention and treatment; and drug addiction and drug abuse prevention and treatment.
Montana	(1967)	State Board of Public Institutions, Division of Mental Hygiene	Direct operation of facilities or by contract	Not to exceed 50%.	Governmental agencies; regional or local private or public services; and private professional persons or hospitals.	Inpatient; outpatient; partial hospitalization; emergency; consultation; education; research; and mental retardation.

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Nebraska	(1974)	Department of Public Institutions	Contracts	Seventy-five percent	Any approved public or private agencies or individuals.	Inpatient; outpatient; partial care service; 24-hour emergency; consultation and educational; specialized services as Federal legislation may require, and other forms of preventive treatment and rehabilitation for mental health, drug abuse and alcoholism.
Nevada	(1965)	Mental Hygiene Division	Grants	Seventy percent.	Counties or combination of counties.	Inpatient; outpatient; partial services such as day, night, and weekend care; emergency services, consultation, and information. (Must have at least two).
New Hampshire	(1965)	Commissioner of Health and Welfare	Grants	Sixty-seven percent. (If locality cannot meet matching it may receive $7,500 the first year of operation and 33-1/3% the second year of operation.	Cities; counties; towns; and non-profit corporations	Diagnostic and treatment; consultation; information; education; prevention; and rehabilitation.

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
New Jersey	(1957)	Department of Human Services, Division of Mental Health and Hospitals	Grants	Not to exceed 60% with a per capita limit of $1.00.	Counties; municipalities; boards of education; and non-profit corporations.	Comprehensive.
New Mexico	(1975)	Hospitals and Institutions Department	Purchase of services	Unspecified in the law.	Community mental health boards.	Inpatient; outpatient; and preventive services for mental and emotional disorders.
New York	(1954)	Department of Mental Hygiene	Grants	Fifty percent of net operating expenditures. For counties less than 200,000, 75% of the first $100,000 of net expenditures each year and 33-1/3 of capital expenditures.	Counties and New York City.	Inpatient; outpatient; emergency; prevention; partial hospitalization; consultation and education; diagnostic and referral; rehabilitation, including vocational; educational; and training programs; precare and aftercare; staff training; research and evaluation. Comprehensive services for mentally disabled; mentally retarded; developmentally

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
New York (con't)						disabled; alcohol abusers or substance abusers.
North Carolina	(1963)	Commission for Mental Health and Mental Retardation Services, Department of Human Resources	Grants and contracts	Sixty-five percent of first $30,000 of expenditures, 50% of the balance.	Counties or municipalities of over 25,000 which have local mental health authorities.	Clinic services; prevention; mental health education; mental retardation; and drug abuse and alcoholism treatment.
North Dakota	(1965)	Division of Mental Hygiene	Grants and contracts	Not to exceed 40%.	Cities; counties; and combinations thereof; and nonprofit corporations	Mental health and retardation units.
Ohio	(1967)	Division of Mental Hygiene	Grants	Seventy-five percent can be increased when necessary at the discretion of the Director. State reimbursement funds	Counties or combination of counties having a population of at least 50,000 must establish mental health services programs.	Must provide diagnostic and treatment services plus at least one of the following: inpatient; partial hospitalization; rehabilitation; consultation; in-

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Ohio (con't)				shall be made available at an amount of not less than $1.00 per resident of the county or counties served by the program.		formation; education; prevention; emergency; research and training; mental retardation; and alcohol treatment.
Oklahoma	(1969)	Department of Mental Health	Contracts	Not to exceed 50%.	Public agencies; and public or private non-profit mental health facilities.	Comprehensive services; diagnostic and treatment services in outpatient facilities; and treatment programs in drug care facilities.
Oregon	(1961)	Mental Health Division of the State Department of Human Resources	Contracts	Maximum of 50% state funds for basic services, and maximum of 100% state funds for alternative services.	Counties or county designees.	Outpatient; aftercare; training; consultation and education; prevention; mental retardation; emotional disturbances; and alcohol and drug services. Subject to availability of funds, the following alternative services will

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Oregon (con't)						be provided; emergency; day and/or night care treatment; residential care and treatment, continuity of care, and inpatient.
Pennsylvania	(1966)	Department of Public Welfare	Grants	Ninety percent for all services and 100% for mental retardation services.	Counties must provide local mental health services programs.	Comprehensive including mental retardation, drug and alcohol abuse service.
Rhode Island	(1962)	Director of State Department of Mental Health, Retardation, and Hospitals	Grants	Not to exceed 70%.	Cities; towns; and non-profit corporations.	Inpatient; outpatient; rehabilitation; consultation; information; education; collaborative services for prevention of mental disabilities, and mental retardation.

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
South Carolina	(1961)	Mental Health Commission	Grants	Limited only by state appropriations.	Counties; cities; towns; and non-profit corporations.	Inpatient; outpatient; partial hospitalization; crisis and emergency services; consultation and education; substance abuse; children; elderly; precare; aftercare; alternate care; transitional care; and other specialized programs.
Texas	(1965)	Department of Mental Health and Mental Retardation	Grants	Unspecified in the law.	Community centers serving a population of 75,000 or more.	Research; prevention; treatment; and rehabilitation of the mentally ill and retarded.
Utah	(1961)	Division of Mental Health, Department of Social Services	Contracts	Forty percent for outpatient programs and 90% for comprehensive programs.	County; city; or a combination of several counties or several cities.	Outpatient; rehabiliation; education; consultation; and "other necessary activities."

APPENDIX I (con't)

STATE FUNDING FOR COMMUNITY MENTAL HEALTH CENTERS IN 47 STATES

State	Date of Enactment	Act Administered by	Mechanism for Allocating State Funds	Maximum State Matching Share	Eligible Recipients of State Funds	Mental Health Services Eligible for State Support
Vermont	(1957)	Department of Mental Health	Grants	Not to exceed 67%.	Non-profit corporation.	Residential; rehabilitative; vocational; day treatment; inpatient; outpatient; emergency; and prevention services for the mentally ill and mentally retarded.
Virginia	(1968)	Department of Mental Health and Mental Retardation	Grants and contracts	Not to exceed 90% of expenditures for construction and provision of services. Not to exceed 90% of expenditures for staffing community.	Counties of 50,000 or more; cities of 75,000 or more; or combinations of counties and cities with a combined population of 50,000 or more.	Collaborative and cooperative; prevention; information; education; consultative; outpatient diagnostic and treatment; research; evaluation; and training of personnel; aftercare; therapeutic; transitional; partial hospitalization; emergency; drug abuse and alcoholism; and other mental health, mental retardation and drug problems as necessary

APPENDIX II

Selected Zero-Based Budget Forms

The following Zero-Based Budget (ZBB) Forms have been selected to acquaint the reader with this specific type of budget presentation. These forms represent the two major kinds of ZBB forms. First are the forms used to present all the decision units or packages in each CMHC. Each decision package, which represents one program, must be presented using form B/10, B/21 and B/22. Second are the forms used to present the performance and workload measures. Each CMHC must complete one set of B/25 forms. The information presented in these forms must be summarized and presented on a B/23 form also.

For each program (also referred to as a decision unit, unit, or decision package) for which a center considers seeking funds, four complete sets of forms must be prepared. In the final approved budget for a fiscal year, each program will be presented on the B/10 and B/22 forms. This final ZBB document is also the center's plan for the fiscal year.

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TRANS-ACTION CODE
☐ INITIAL
☐ SUPPLEMENTAL
☐ SPECIAL GRANT
☐ NEW OU

FY 1980
COMMUNITY MHMR CENTER BUDGET
BUDGET DETAIL

B/10	
CENTER CODE	
OU CODE	

NAME OF CENTER ______________________________

TRANSMITTAL DATE ____/____/____

PAGE _____ of _____ PAGES

ORGANIZATIONAL UNIT NAME Used for each unit (Use B-11 of totally contract services)			PROGRAM CATEGORY	CODE #
OU STREET ADDRESS AND TOWN			CLASSIFICATION	CODE #
PRIOR YEAR NAME, IF CHANGED	BUDGETED PERIOD	FROM MO/DAY	THRU MO/DAY	UNIT EMPHASIS ☐ MH ☐ ALCOHOL ☐ MR ☐ DRUG

BUDGET CATEGORIES		BUDGETED AMOUNT
1. PERSONNEL		
a. Salaries & Wages	(010)	
b. Salary and Merit Increases and Other Adjustments	(011)	
c. Fringe Benefits	(020)	
d. Consultation & Professional Fees		
(1) Direct Patient Services	(030)	
(2) Other	(040)	
2. TRAVEL - Staff & Board of Trustees Members	(050)	
3. CONSUMABLE ITEMS		
a. Drugs	(060)	
b. Food	(070)	
c. Other (Office, Hospital, Medical, School, Etc.)	(080)	
4. EQUIPMENT & FURNITURE		
a. Purchase	(090)	
b. Rental	(100)	
c. Repair & Maintenance	(110)	
5. BUILDING		
a. Rent	(120)	
b. Remodeling & Renovation	(130)	
c. Repair & Maintenance	(140)	
6. VEHICLE		
a. Purchase	(150)	
b. Rental	(160)	
c. Operating & Maintenance Costs	(170)	
7. CONTRACTS WITH SERVICE AGENCIES	(180)	
8. OTHER		
a. Postage, Telephone	(190)	
b. Laboratory Expenses	(191)	
c. Client Transportation	(192)	
d. Annual Audit	(193)	
e. Insurance	(194)	
f. Client Wages	(195)	
g. Utilities	(196)	
h.	(197)	
i.	(198)	
j.	(199)	
k.	(200)	
9. GRAND TOTAL	(300)	

CS/TDMHMR - 6/1/72, 6/1/73, 11/7/73, 5/20/75, 5/15/77

FY 1980

☐ CLASSIFIED
☐ UNCLASSIFIED

COMMUNITY MHMR CENTER BUDGET
PERSONAL SERVICES SCHEDULE
(FOR BUDGETING AND REPORTING CHANGES IN PERSONNEL)

B/21
CENTER CODE
OU CODE

NAME OF CENTER ______________________________

ORGANIZATIONAL UNIT NAME Use one for each center - No summary forms required

TRANSMITTAL DATE ____/____/____

PAGE _____ OF _____ PAGES

POS. NO.	POSITION TITLE EMPLOYEE NAME	CLASS NUMBER	GROUP	% OF TIME	EMPLOYMENT PERIOD FROM MO/DAY	EMPLOYMENT PERIOD THRU MO/DAY	ACTUAL MONTHLY SALARY	BUDGETED ANNUAL SALARY	% OF MONTHLY SALARY INCREASE

NO. OF FULL-TIME EQUIVALENT POSITIONS (last page only)

TOTAL (LAST PAGE ONLY)

CS/TDMHMR - 6/1/72, 6/1/73, 11/1/73, 3/8/74, 5/15/77

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☐ SPECIAL GRANT
☐ NEW OU

FY 1980
COMMUNITY MHMR CENTER BUDGET
NARRATIVE DESCRIPTION

B/22
CENTER CODE

OU CODE

NAME OF CENTER

TRANSMITTAL DATE ____/____/____

PAGE ____ OF ____ PAGES

ORGANIZATIONAL UNIT NAME Use one for each unit(program)	PROGRAM CATEGORY	CODE #
OU STREET ADDRESS AND TOWN	CLASSIFICATION	CODE #

PRIOR YEAR NAME, IF CHANGED	BUDGETED PERIOD	FROM MO/DAY	THRU MO/DAY

UNIT EMPHASIS
☐ MH ☐ ALCOHOL
☐ MR ☐ DRUG

IF SERVICE PROVIDED BY CONTRACT WITH SERVICE AGENCY, LIST NAME AND AMOUNT
NAME: ______________________________ $ ____________

	FY 1979 ESTIMATE	FY 1980 BUDGETED
Amount budgeted for this organizational unit		
No. of Positions this organizational unit		
Days and Hours of Operation		
Period of Operation during Fiscal Year		
Estimated Service Cost per client per Hour/Day (Specify)		
WORKLOAD MEASURES	**MEASURES**	**MEASURES**
Static Capacity		
Dynamic Capacity - No. of clients served per year		

SEE CONTINUATION PAGE

CS/TDMHMR - 5/16/77

CONTINUATION PAGE

NARRATIVE DESCRIPTION

F Y 1980

COMMUNITY MHMR CENTER BUDGET

NAME OF CENTER

B/22
CENTER CODE

OU CODE

ORGANIZATIONAL UNIT NAME
Use one for each unit(program)

PAGE __ OF __

OBJECTIVE STATEMENT & TARGET POPULATION

DESCRIBE MEANS OF PERFORMING SERVICE (INCLUDING A DESCRIPTION OF CHANGES, IF ANY, FROM PRIOR FISCAL YEAR OR APPROVED BUDGET)

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FY 1980

COMMUNITY MHMR CENTER BUDGET

STANDARD PERFORMANCE/WORKLOAD MEASURES

B/25
CENTER CODE
PGM CODE

Use one for center - summary data

NAME OF CENTER

TRANSMITTAL DATE ____/____/____

Page 1 of __ Pages

Performance/Workload Measures $\% = \frac{N}{D} \times 100$

	CENTER ADMINISTRATION	Planned Performance	Refer to B/26 Item No.
2.	Percent Management Audit recommendations implemented		
	Number of Management Audit recommendations implemented (Numerator (N)		
	Number of Management Audit recommendations made (Denominator (D)		
3.	Percent compliance with principles and standards		
	Number of principles and standards in compliance (Numerator (N))		
	Number of principles and standards promulgated (Denominator (D)		
9.	Number of full-time equivalent (FTE) employees budgeted beginning of fiscal year		
10.	Number of FTE Center Employees on payroll at end of fiscal year		
11.	Number of clients served by entire Center		
12.	Number of persons in center service area on State School active waiting list		
13.	Number of persons on State School active waiting list receiving Center services		

	SCREENING AND REFERRAL/EMERGENCY	Planned Performance	Refer to B/26 Item No.
1A.	Targeted/actual direct admissions to State Hospitals		
1B.	Targeted/actual direct admissions to State Schools		
2.	Percent persons from center area screened prior to admission to TDMHMR State facility		
	Number of persons screened (Numerator (N)		
	Number of admissions (1A + 1B + admissions to Center for HD (Denominator) (D)		
4.	Total number of persons screened (A+B+C+D+E)		
	A. Number of persons admitted to center programs		
	B. Number of persons referred to State Schools		
	C. Number of persons referred to State Hospitals		
	D. Number of persons referred to other agencies		
	E. Number of persons not referred		

NOTE: Numbers to the left of measure description refer to a corresponding number in the Performance/Workload Measures definitions.

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7/7/78

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☐ SPECIAL GRANT

FY 1980
COMMUNITY MHMR CENTER BUDGET
STANDARD PERFORMANCE/WORKLOAD MEASURES

B/25
CENTER CODE
PGM CODE

Use one for center - summary data

NAME OF CENTER

TRANSMITTAL DATE ____/____/____

Page 2 of _ Pages

OUTPATIENT/CLINIC SERVICES	Planned Performance	Refer to B/26 Item No.
1. Percent change in the number of clients served $(\% = (\frac{\text{current year}}{\text{prior year}} - 1) \times 100)$		
Number of clients served in FY 1979 ____	▨	▨
2. Number of clients served		

Performance/Workload Measures $\% = \frac{N}{D} \times 100$

SPECIAL EDUCATION CLASSES	Planned Performance	Refer to B/26 Item No.
1. Percent of special education students who were accepted by public school programs		
3. Total average daily attendance		
A. Ages 0 through 2		
B. Ages 3 through 20		
C. Ages 21 and over		
4. Total number of sutdents served per year (Denominator (D) for 1. above)		
A. Ages 0 through 2		
B. Ages 3 through 20		
C. Ages 21 and over		
5. Number students accepted by public school programs (Numerator (N) for 1. above)		

NOTE: Numbers to the left of measure description refer to a corresponding number in the Performance/Workload Measures definitions.

CS/TDMHMR
11/78

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☐ SUPPLEMENTAL
☐ SPECIAL GRANT

FY 1980
COMMUNITY MHMR CENTER BUDGET
STANDARD PERFORMANCE/WORKLOAD MEASURES

B/25
CENTER CODE
PGM CODE

Use one for center - summary data
NAME OF CENTER

TRANSMITTAL DATE ____/____/____

Page 3 of _ Pages

Performance/Workload Measures $\% = \frac{N}{D} \times 100$

SHELTERED WORK TRAINING	Planned Performance	Refer to B/26 Item No.
1. Percent of clients served who are placed in sheltered/competitive employment		
3. Static capacity		
4. Number of clients served per year (Denominator (D) for 1. above)		
5. Number of clients placed in sheltered/competitive employment (Numerator (N) for 1. above)		

DAY/EVENING CARE	Planned Performance	Refer to B/26 Item No.
2. Static Capacity cf Program		
3. Number of clients served per year		
5. Average daily attendance		

NOTE: Numbers to the left of measure defintion refer to a corresponding number in the Performance/Workload Measures definitions.

CS/TDMHMR
7/7/78

TRANSACTION CODE

☐ INITIAL
☐ SUPPLEMENTAL
☐ SPECIAL GRANT

FY 1980
COMMUNITY MHMR CENTER BUDGET
STANDARD PERFORMANCE/WORKLOAD MEASURES

Use one for center - summary data

NAME OF CENTER

TRANSMITTAL DATE ____/____/____

B/25
CENTER CODE
PGM CODE

Page 4 of _ Pages

Performance/Workload Measures $\% = \frac{N}{D} \times 100$

ALTERNATE RESIDENTIAL CARE	Planned Performance	*Refer to B/26 Item No.
1. Percent of clients served in program discharged/furloughed TDMHMR State facility		
4. Total number of beds		
A. MH		
B. MR		
C. Alco		
D. Drug		
5. Total average daily client population		
A. MH		
B. MR		
C. Alco		
D. Drug		
6. Total number of clients served (Denominator (D) for 1. above)		
A. MH		
B. MR		
C. Alco		
D. Drug		
7. Total number of clients discharged from TDMHMR facilities (Numerator (N) for 1. above)		
A. State Schools		
B. State Hospitals		
C. State Center for Human Development/Rio Grande State Center		

CS/TDMHMR
7/7/78

NOTE: Numbers to the left of measure definition refer to a corresponding number in the Performance/Workload Measures definitions.

TRANSACTION CODE

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☐ SPECIAL GRANT

FY 1980
COMMUNITY MHMR CENTER BUDGET
STANDARD PERFORMANCE/WORKLOAD MEASURES

B/25
CENTER CODE
PGM CODE

Use one for center - summary data
NAME OF CENTER

TRANSMITTAL DATE ____/____/____

Page 5 of _ Pages

Performance/Workload Measures $\% = \frac{N}{D} \times 100$

24 HOUR RESIDENTIAL CARE	Planned Performance	Refer to B/26 Item No.
1. Percent of clients served in program discharged/furloughed TDMHMR State facility		
2. Percent of clients moved to alternate residential care/more independent living		
Number of clients moved (Numerator (N) for 2. above)		
4. Total number of beds		
A. MH		
B. MR		
C. Alco		
D. Drug		
5. Total average daily client population		
A. MH		
B. MR		
C. Alco		
D. Drug		
6. Total number of clients served (Denominator (D) for 1. & 2. above)		
A. MH		
B. MR		
C. Alco		
D. Drug		
7. Total number clients discharged from TDMHMR facilities (Numerator (N) for 1. above)		
A. State Schools		
B. State Hospitals		
C. State Centers for Human Development/Rio Grande State Center		

NOTE: Numbers to the left of measure definition refer to a corresponding number in the Performance/Workload Measures definitions.

CS/TDMHMR
7/7/78

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FY 1980
COMMUNITY MHMR CENTER BUDGET
STANDARD PERFORMANCE/WORKLOAD MEASURES

B/25
CENTER CODE
PGM CODE

Summary of center-wide data
NAME OF CENTER

Transmittal Date ____/____/____

Page 6 of _ Pages

Performance/Workload Measures $\% = \frac{N}{D} \times 100$

CENTER WIDE	Planned Performance	Refer to B/26 Item No.
1. Percent of State facilities clients discharged/furloughed seen within 30 days		
Number seen in center within 30 days (3C + 4C + 5C) (Numerator (N)		
Number discharged/furloughed to area (3 + 4 + 5) (Denominator (D)		
2. Percent State facilities clients discharged/furloughed with joint planning		
Number with joint discharge planning (3A + 4A + 5A) (Numerator (N)		
3. Total number clients discharged/furloughed to Center area from State Hospitals		
A. No. with joint discharge plans		
B. No. "contacted" by center staff after discharge/furlough		
C. No. served within 30 days		
4. Total number clients discharged/furloughed to Center area from State Schools		
A. No. with joint discharge plans		
B. No. "contacted" by center staff after discharge/furlough		
C. No. served within 30 days		
5. No. discharged/furloughed to Centers from Centers for Human Development & Rio Grande		
A. No. with joint discharge plans		
B. No. "contacted" by center staff after discharge/furlough		
C. No. served within 30 days		
6. Average months in community following discharge from TDMHMR facility prior to readmission		
No. of readmissions (Denominator (D)		
Total No. of months (Numerator (N)		

NOTE: Numbers to the left of measure description refer to a corresponding number in the Performance Workload Measures definitions.

CS/TDMHMR
7/7/78

TRANSACTION CODE

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☐ SPECIAL GRANT

B/26
CENTER CODE
PGM CODE

FY 1980
COMMUNITY MHMR CENTER BUDGET
STANDARD PERFORMANCE/WORKLOAD MEASURES
NARRATIVE, COMMENTS AND EXPLANATIONS OF VARIANCES

Use if necessary to provide explanation of variances reported on B/23 forms

NAME OF CENTER

TRANSMITTAL DATE ____/____/____

Page _ of _ Pages

REFERENCE NUMBER	PROGRAM CATEGORY/COMMENTS

CS/TDMHMR
7/7/78

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FY 1980
COMMUNITY MHMR CENTER BUDGET
STATIC & DYNAMIC CAPACITY

B/23
CENTER CODE
PGM CODE

Summary of center-wide data reported on B/25 forms
NAME OF CENTER

TRANSMITTAL DATE ____/____/____

PROGRAM CATEGORY	STATIC CAPACITY					DYNAMIC CAPACITY				
	MH	MR	ALC	DRUG	TOTAL	MH	MR	ALC	DRUG	TOTAL
SCREENING & REFERRAL/ EMERGENCY	NO ENTRIES REQUIRED									
OUTPATIENT/ CLINIC SERVICES	NO ENTRIES REQUIRED									
SPECIAL EDUCATION CLASSES										
DAY/EVENING CARE										
SHELTERED WORK TRAINING										
ALTERNATE RESIDENTIAL CARE										
24 HOUR RESIDENTIAL CARE										

CS/TDMHMR
5/16/77, 11/77, 7/7/78

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IDRA MENTAL HEALTH RESEARCH PROJECT
NATIONAL ADVISORY COMMITTEE

Carlos H. Arce, Ph.D.
Project Director
National Chicano Research Network
5080 Institute for Social Research
University of Michigan
Ann Arbor, MI 48106

Carmen Carrillo, Ph.D.
Director
City and County of San Francisco Community
Mental Health Services
Mission Mental Health Center
2940 16th St., Room 319
San Francisco, CA 94103

Floyd Martinez, Ph.D.
Executive Director
Boulder Community Mental Health Center
1333 Iris Ave.
Boulder, CO 80302

Amado M. Padilla, Ph.D.
Director
Spanish Speaking Mental Health Research Center
UCLA
Los Angeles, CA 90024

Marta Sotomayor, Ph.D.
Special Assistant to the Administrator
for Drug Abuse, Mental Health and Alcohol
5600 Fisher Lane
Rockville, MD 20857

Ernesto Suazo
Executive Director
New Mexico Council of Community Mental Health
Service
620 Camino de Salud, N.E.
Albuquerque, NM 87131

IDRA MENTAL HEALTH RESEARCH PROJECT

STATE OF TEXAS ADVISORY COMMITTEE

Shirley Camfield
Vice-President/Communications NHMA
1113 Roaring Spring Rd.
Fort Worth, Texas 76114
(817) 732-6133

Juan Chavira, Ph.D.
Dept. of Family Practice
University of Texas Health
Science Center
7703 Floyd Curl Drive
San Antonio, Texas 78284
(512) 223-6361 Ext. 496

Israel Cuellar, Ph.D.
Director Houston Hall
San Antonio State Hospital
P.O. Box 23310
Highland Hills Station
San Antonio, Texas 78223
(512) 532-8811 Ext. 491

John Estrada
Coordinator - Drug Abuse Services
El Paso Center for MHMR
720 E. Yandell
El Paso, Texas 79902
(915) 532-1481

Janie Farris
Bay Shore MHMR Center
2001 Cedar Bayou
Baytown, Texas 77520
(713) 427-8544

Adela G. Freymann
Division Director
Medical Assistance Program
City of Austin Health Dept.
1313 Sabine
Austin, Texas 78701
(512) 474-6581 Ext. 302

Fernando Galan, Ph.D.
Assistant Dean
Graduate School of Social Work
University of Houston
4800 Calhoun
Houston, Texas 77004
(713) 749-3814

Roberto Jimenez, M.D.
Director
Southwest Mental Health
Mental Retardation
2415 W. Southcross
San Antonio, Texas 78211
(512) 924-1411

Othon Medina
Registered Professional Engineer
1600 Globe
El Paso, Texas 79915
(915) 543-5357

Alfonso Mirabal
U.S. Dept. of Commerce
Bureau of the Census
1100 Commerce
Dallas, Texas 75202
(214) 767-0625

John Moore, II
Texas Dept. of Human Resources
P.O. Box 2960
Austin, Texas 78769
(512) 441-3355

Dolores Briones Ybarra
Legislative Aid
State Representative Paul Moreno's Office
2314 Montana
El Paso, Texas 79903
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